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ABSTRACT

This report on the status of the black elderly in the United States is based on six issue forums that the National Caucus and Center on Black Aged, Inc., conducted throughout the United States in 1986; and on three House Select Committee on Aging hearings on this subject. Statistics pertaining to the following issues affecting older blacks are addressed: (1) income and employment needs; (2) health needs; (3) budget issues; (4) housing issues; (5) impact of crime; and (6) service needs. Older blacks are the poorest group among the elderly and they are among the most impoverished groups in our nation today. They are also among the most poorly housed groups, and are more likely to experience health problems than aged persons in general. They are at greater risk of being criminal victims than other Americans. As a group, older blacks have borne more social, economic, and psychological damage than other groups because of racial discrimination. The United States has the resources and the capacity to enable all older American to live in dignity and self-respect. Recommendations for improving each aspect of the status of older blacks are offered. (BJV)

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[COMMITTEE PRINT]

THE STATUS OF THE BLACK ELDERLY IN THE UNITED STATES

A REPORT

BY THE

NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

FOR THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES ONE HUNDREDTH CONGRESS FIRST SESSION

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JULY 1987

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LETTER OF TRANSMITTAL

SELECT COMMITTEE ON AGING,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

To Members of the House Select Committee on Aging:

Transmitted herewith is a report prepared by the National Caucus and Center on the Black Aged, Inc. for the Select Committee on Aging. The report is entitled, "A Report on the Status of the Black Elderly in the United States."

This compilation of data was obtained from a series of congressional hearings and public forums held across the country focusing directly on the unique problems of the Black elderly.

It is with deep appreciation that we provide this document to you in the interest of aging issues.

EDWARD R. ROYBAL, *Chairman.*

FOREWORD

A Report on the Status of the Black Elderly in the United States

This report was compiled by the National Caucus and Center on the Black Aged, Inc. for the Select Committee on Aging. Several hearings were conducted by the House Select Committee on Aging focusing on the problems of the Black elderly. Separately, the National Caucus and Center on Black Aged (NCBA) has conducted a number of forums across the country to obtain data on the economic status of the Black elderly. These forums have disclosed that the Black elderly suffer from a myriad of problems involving health care, income security, crime and other problems which disproportionately impact the Black elderly living in their communities. It is my sincere hope that the information which is provided in this report will serve to spur the Congress and the nation to devote greater resources in aiding Black and other minority elderly.

The major source of support for elderly Blacks and other senior citizens, the Federal government, has been subjected to a number of dramatic budget reductions during the 1980's. One example occurred in 1983 when the elderly did not receive a cost-of-living adjustment (COLA) under Social Security, a benefit which had normally been confirmed in previous years of inflation. These and other reductions in categorical benefits furnished by the Federal government have had a disproportionate and adverse impact on the health and well-being of many of the Black elderly.

There are a number of major problems faced by the elderly. Among the most prominent of these problem areas include housing, crime, and a lack of adequate human service programs. Among the Black elderly, these problems are compounded and magnified due to a lack of resources and an inability of the Federal government to disseminate these limited resources to members of the elderly Black community.

One critical area of need, for example, involves providing affordable housing to elderly members of the Black community who need such housing. Housing is one of the major obstacles faced by aged Blacks whether they live in urban ghettos or rural slums. According to information provided in this report, even though their homes may be dilapidated, their meager incomes make it impossible for them to move to more suitable housing or repair existing homes.

Crime is another major problem which confronts the Black community. Many elderly Blacks are concerned that, in the absence of adequate police protection and secured housing, they may be subjected to major crimes from which they can never recover, either financially or physically. As such, crimes are often unreported or

underreported in the Black community and, in all too many Black communities, there is a pervasive fear of crime which effectively imprisons the elderly in their homes. Such fear also affectively cuts off many minority elderly from their families and from necessary human service programs.

Minorities and Blacks are underrepresented in Older American Act services and programs. However, the minority elderly, including Blacks, typically have a greater need for supportive services. In fact, it has been documented that the minority elderly typically need two to three and one-half times as much in the way of human and other supportive services as compared to older whites. This situation appears to be worsening, particularly in terms of minority participation under Title III-B supportive service programs.

I believe this report provides the kind of information that will enhance the understanding of the Congress and the nation concerning the needs of the Black and minority elderly communities. I hope that this information further spurs the efforts of the public and private sector to fashion appropriate remedies and services that will begin to address some of the needs that are outlined in this report. If there is truly to be a "safety net" then it will take the best efforts of us all to fashion that safety net in a manner that adequately addresses the concerns embodied throughout this report.

As Chairman of the Select Committee on Aging, I would wish to extend my deep appreciation to Fernando Torres-Gil, Roger Thomas, and Diana Jones of my staff. I would also like to thank my colleague and good friend Congressman George Crockett (D-MI) and his legislative assistant, Loree Cook for her editorial assistance. Many thanks also to my colleague Congressman Harold Ford (D-TN) and his legislative assistant, John Murdock.

EDWARD R. ROYBAL, *Chairman.*

PREFACE

The National Caucus and Center on Black Aged, Inc., is pleased to submit this report on the status of aged Blacks in the United States. Our report is based on six issue forums which NCBA conducted throughout the United States in 1986 and three House Select Committee on Aging hearings on this subject in Detroit, Memphis, and Washington, D.C.

Eleven members of the Congressional Black Caucus and several members from the House Select Committee on Aging participated in the nine forums and hearings in eight major cities throughout the United States. More than 100 senior citizens and other experts testified.

Their message was brief but blunt. Older Blacks are the poorest of the poor among the elderly and they are among the most impoverished groups in our nation today. By virtually any standard of measurement, their quality of life is below that for most other older Americans.

Aged Blacks are among the most poorly housed groups in our society today. They are more likely to experience health problems than aged persons in general. And, they usually run a greater risk of being criminal victims than other Americans.

As a group, older Blacks have borne more social, economic, and psychological damage than any other group because of *de jure* and *de facto* racial discrimination. The forums and hearings, though, demonstrate that elderly Blacks have great resilience. They have faced formidable odds throughout their lives. Yet, they have survived and have made important contributions to our Nation.

However, older Blacks are still among the most disadvantaged groups in our entire society today. NCBA's report is not only designed to improve public understanding about the true state of affairs for aged Blacks, but also to chart a new course to improve the quality of life for elderly Blacks and other low-income aged persons in the United States. Our nation has the resources and the capacity to enable all older Americans to live in dignity and self-respect. However, a catalyst is needed to provide the necessary impetus to develop a long awaited comprehensive national policy to improve living conditions for aged Blacks and other low-income elderly persons. It is NCBA's hope that our findings and recommendations in this report can be the energizing force to launch this long overdue action.

Again, we wish to extend our heartfelt thanks to the House Select Committee on Aging and to you in particular, Mr. Chairman, for your cooperation, participation and assistance in promoting this comprehensive study.

We also want to pay special tribute to Congressman George W. Crockett, Jr. for his leadership and contribution to these forums. He has given generously of his time, his enormous talent, and his analytic skills.

ACKNOWLEDGMENTS

The Select Committee on Aging wishes to extend deep appreciation to Mr. Samuel J. Simmons, President of the National Caucus and Center on the Black Aged, Inc., and to the National Caucus and Center on Black Aged board members, its counsel, David A. Affeldt, Esq., the Villers Foundation, the Office of Legislative Affairs and State Legislative Committees, American Association of Retired Persons; and Members of the Congressional Black Caucus for their contributions to this report.

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EXECUTIVE SUMMARY

I. INTRODUCTION

Many people know in a general way that the quality of life for older Blacks is significantly lower than for other groups in our society. But, they are often surprised—sometimes shocked—by the degree of deprivation among aged Blacks.

Older Blacks are the poorest of the poor among the elderly. No other major aged racial or ethnic group has a poverty rate as high as elderly Blacks—not aged Indians, not older Hispanics, not elderly Pacific/Asians, and not any other major group.

Many senior citizens did not become poor until they became old. But, this is simply not true for a large proportion of aged Blacks. They have known poverty all their lives—from the moment of conception until death. Advancing age simply intensifies their problems.

Many older Blacks now encounter the "double jeopardy" of age and race. They were raised at a time when more flagrant discrimination existed. Many were forced to drop out of school for economic or for other reasons.

To a very large degree, they were shortened by the existing political, social, and economic system. Today, they are constantly aware of denied cultural, educational, and monetary advantages. The net effect is that large numbers now enter the "senior citizen" ranks with insufficient financial resources. The facts speak for themselves.

This report is based upon six issue forums that the National Caucus and Center on Black Aged conducted throughout the United States in 1986 and three House Select Committee on Aging hearings in Detroit, Memphis, and Washington, D.C. Eleven members from the Congressional Black Caucus and several members from the House Select Committee on aging participated in nine forums in eight major cities throughout our nation. More than 100 witnesses—including senior citizens, professionals in the field of aging, elected officials, government administrators, directors of services programs, and others—testified at these forums and hearings.

The following summary highlights the key findings and recommendations from this comprehensive study.

II. INCOME AND EMPLOYMENT

Aged Blacks are three times as likely to be poor as elderly Whites. In 1985, 31.5 percent of all Blacks 65 years or older lived in

poverty, compared to 11.0 percent for all older Whites. Overall, 717,000 aged Blacks were poor.[1]

This, though, is just the tip of the iceberg. Nearly 900,000 more elderly Blacks were economically vulnerable. Their incomes did not exceed twice the poverty thresholds: about $10,300 for an older individual and approximately $13,000 for an elderly couple in 1985. The bottom line is that seven out of ten (71.1 percent) older Blacks are either poor or economically vulnerable.

The situation is especially precarious for single unrelated elderly Black women or those who live with nonrelatives. They are clearly one of the most economically deprived groups in our society today. About seven out of every eight (87.9 percent) are either poor or economically vulnerable.

Inadequate income in retirement is the number one dilemma for older Blacks. No other problem looms as large as the retirement income crisis which already affects many aged Blacks and threatens to engulf others. Inadequate income is one of the root causes for virtually every problem confronting elderly Blacks, whether it is poor health, an inappropriate diet, dilapidated housing or other living conditions.

Five out of eight (64.9 percent) aged Black females had an annual income below $5,000 in 1985, and one out of six (17.0 percent) had less than $3,000.

Older Blacks were 1.8 to 2.4 times more likely to be unemployed than aged Whites in 1985. Elderly Blacks who are able to work earn less than older Whites who are employed. The median usual weekly earnings for a full-time Black wage earner 65 years or older in 1985 was just 55.6 percent of that for a comparably situated aged White wage earner.

Key recommendations

—The federal Supplemental Security Income standards should be raised above the poverty lines.
—The SSI benefits standard should not be reduced by one-third when aged, blind or disabled recipients live in the household of another for a full month and receive in-kind maintenance and support.
—A mandatory pension system should be established to assure that all workers receive at least a minimum pension.

III. HEALTH

A health care crisis afflicts hundreds of thousands of Blacks 65 years or older. Quite often, aged Blacks suffer more intense health care problems than other older Americans.

Life expectancy is significantly shorter for Blacks than Whites. A White male born in 1982 can expect to live, on the average, 6.6 years longer than Black males; 71.5 years versus 64.9 years. Similarly, White females are projected to live 5.3 years longer than Black females: 78.8 years compared to 73.5 years.

[1] A person 65 years or older was considered poor in 1985 under the Census Bureau definition if his or her annual income fell below $5,196 ($6,503 for an elderly couple).

More than one-half (55 percent) of all Blacks 65 years or older consider their health to be poor or just fair, in contrast to one-third (33 percent) among aged Whites.

Elderly Blacks emphasized during the forums and the hearings that they have been victimized by our two-tier health system. They often receive "welfare medicine," while the more affluent or those with decent company health insurance plans receive quality care.

Medicare and Medicaid protection has been whittled away in recent years by rapidly rising deductible and coinsurance charges and cutbacks in omnibus budget reconciliation bills. For example, the Medicare inpatient hospital deductible charge has jumped by 155 percent during the past six years, from $204 in 1981 to $520 in 1987.

Only a relatively small proportion of aged Blacks and other low-income elderly persons actually have Medicaid protection. In fact, about one out of every three (36 percent) non-institutionalized aged poor persons have Medicaid protection.

Key recommendations

—Congress should resist further attempts to cut back Medicare and Medicaid coverage. Older Blacks have been among the major casualties of these reductions. Cost containment should be the primary goal to strengthen the financing of Medicare and Medicaid.

—Our health care system should place a greater emphasis upon preventive measures to ward off illness and to encourage wellness among the elderly.

—As a long-term goal, our nation should enact a universal and comprehensive national health insurance program with built-in cost controls. Until this can be achieved, Medicare should be improved by capping out-of-pocket payments for hospital and medical services, as well as closing gaps for crucial health care needs.

IV. BUDGET ISSUES

Older Americans from all walks of lives and all sections of our nation have been hit hard by budgetary cuts in recent years. Yet, many opinion leaders believe that the elderly have escaped largely unscathed from the budget knife. However aged Blacks and other older Americans have clearly suffered.

Social Security, the major source of support for elderly Blacks and other senior citizens, has been cut on a number of occasions during the 1980's. The most substantial reduction occurred in 1983 when the aged did not receive a cost-of-living adjustment (COLA) that year. The six-month delay in the COLA—from July 1983 to January 1984—cost Social Security beneficiaries an estimated $4.2 billion in lost benefits in fiscal year 1986.

Budget cuts have helped to cause Medicaid coverage for low-income older Americans to fall by 316,000 from 1980 to 1985.

Conventional public housing starts have dropped by 79 percent within a five-year period, from 36,365 in FY 1980 to 7,714 in FY 1985. About two out of every five households living in public or

subsidized housing in fiscal year 1980 were headed by an aged individual.

The Gramm-Rudman-Hollings balanced budget amendment has further intensified the budgetary squeeze for programs serving older Americans and elderly Blacks. The automatic spending reduction feature in the amendment produced several negative effects for elderly Blacks and other older Americans during FY 1986, including:

—The elimination of about 2,800 positions under the Senior Community Service Employment Program for low-income persons 55 years or older.

—Funding for the elderly nutrition program was cut by $17.4 million, causing meals to be reduced by an estimated 4.1 million from 1985 to 1986.

Key recommendations

—A more balanced approach is needed to reduce the federal budget deficit. A greater emphasis should be placed on closing loopholes in the tax law. In addition, Congress must search for a fair and effective means to reduce spending. Congress must continue to be vigilant in preventing wasteful spending at the Pentagon and other agencies. Every effort should be made to avoid cutbacks for programs serving the poor and disadvantaged.

—Congress should vote cuts in programs on the basis of budgetary considerations and the merits of the particular programs, rather than resorting to a ratification of across-the-board reductions as under the Gramm-Rudman-Hollings (GRH) amendment. Congress should repeal the GRH amendment and establish realistic deficit target goals which are approved by a recorded vote. An enforcement mechanism should also be established, either through the appropriations or budgetary process.

V. HOUSING

Housing is the number one expenditure for the elderly. Many older Americans spend at least one-third of their income for housing. A significant percentage spend substantially more, particularly older Blacks.

Housing is perhaps the most visible sign of deprivation among aged Blacks, whether they live in urban ghettos or rural slums. One out of every three elderly Blacks considered their housing to be unsuitable, according to a 1981 Louis Harris Poll commissioned by the National Council on the Aging.

Elderly Blacks were 3½ times as likely as older Whites to be without plumbing for their exclusive use, according to the 1980 Census. About three out of seven (43.5 percent) houses occupied by aged Blacks lacked central heating.

Today numerous older Blacks find themselves in an impossible housing situation. Their homes may be old and dilapidated. But, their meager incomes make it impossible for them to move to more suitable housing or to repair their existing homes.

These problems have been exacerbated by sharp funding cutbacks for federally-assisted housing in recent years.

Key recommendations

—Our nation should set a goal of at least 200,000 additional housing units per year for older Americans. The public, private for profit, and voluntary sectors should work cooperatively to implement this goal. At the federal level, there should be an appropriate mix of public housing, section 8 assistance, section 202 housing for the elderly and handicapped, and Farmers Home Administration programs to respond to the many and varied housing needs of aged Blacks and other older Americans.
—The congregate housing services program should be a cornerstone in our nation's housing strategy to improve the quality of life for "at risk" older persons who may wind up in a nursing home at a significantly higher public expense.
—Existing laws prohibiting housing discrimination should be fully and vigorously enforced.

VI. CRIME

Persons 65 or older are much less likely to be victims of crime than other age groups, particularly teenagers and persons in their early 20's. These figures are extremely misleading if viewed in isolation, and lead to erroneous conclusions.

First, a substantial amount of crime is never reported because older Americans fear retaliation. Consequently, the victimization rates are deceptively low.

Second, the aged tend to be victimized less because large numbers live under a form of house arrest. This solution may provide more security for the elderly, but it also causes them to be imprisoned in their homes, cut off from their families, friends, and vital services.

Third, no statistics can accurately depict the personal trauma and fear of being victimized.

Older Blacks are far more likely to be victimized by criminals than aged Whites. For example, elderly nonwhites (largely aged Blacks) are more than five times as likely to be murder victims than Whites 65 years or older. Aged nonwhite males (primarily older Blacks) are 2.7 times more likely to be robbery victims than elderly White males.

Key recommendations

—A strong handgun control law should be enacted as soon as possible to keep life threatening weapons out of the hands of criminals and other potentially dangerous persons.
—Our nation's efforts to combat crime should focus on preventive techniques. Several methods have already been tested, and the results have generally been positive. The key is to educate the public about effective crime prevention techniques, such as security checks, escort services, neighborhood watches, and the installation of security devices.
—Federal and state criminal courts should impose stiffer sentences against assailants who victimize other Americans.

VII. SERVICES

Aged Blacks and other elderly minorities continue to be underrepresented in Older Americans Act and other services programs. Yet, their need for a wide range of supportive services is normally about two to three and one-half times as great as for older Whites.

The situation is worsening, rather than improving. In fact, the minority participation rate for the Older Americans Act Title III-B supportive services program has plummented by one-fourth (24.7 percent), from 21.9 percent in FY 1980 to 16.5 percent in 1985. This rate represents an all time low for this decade.

Older Blacks have been especially hard hit. Nearly 300,000 fewer Blacks received Title III-B supportive services in 1985 than in 1980. During this decade, the aged Black participation rate has dropped by one-fourth (23.0 percent, from 13.9 percent in 1980 to 10.7 percent in 1985.

A similar pattern exists for elderly Blacks and other older minorities for the Title III-C nutrition program, although the decline has not been quite as severe as for supportive services.

Key recommendations

—The Older Americans Act should state affirmatively that elderly minorities should be served on the basis of their social or physical need for services.

—The Older Americans Act should include specific language to promote the appointment of minorities on advisory committees and other units of area agencies on aging and state offices on aging.

—Improved information and outreach services should be developed to assure that more aged Blacks and other low-income elderly persons participate in "safety net" programs (e.g., Medicaid and food stamps) and the Older Americans Act.

CHAPTER I: INCOME AND EMPLOYMENT NEEDS OF OLDER BLACKS

I. INTRODUCTION

Many people know in a general way that the quality of life for older Blacks is significantly lower than for other groups in our society. But, they are often surprised—sometimes shocked—by the degree of deprivation among aged Blacks.

Older Blacks are the poorest of the poor among the elderly. No other major aged racial or ethnic group has a poverty rate as high as elderly Blacks—not aged Indians, not older Hispanics, not elderly Pacific-Asians, and not any other major group.

Many senior citizens did not become poor until they became old. But, this is simply not true for a large proportion of aged Blacks. They have known poverty all their lives—from the moment of conception until death. Advancing age simply intensifies their problems.

Many older Blacks now encounter the "double jeopardy" of age and race. They were raised at a time when more flagrant discrimination existed. Many were forced to drop out of school for economic or for other reasons.

To a very large degree, they were shortened by the existing political, social, and economic system. Today, they are constantly aware of denied cultural, educational, and monetary advantages. The net effect is that large numbers now enter the "senior citizen" ranks with insufficient financial resources. The facts speak for themselves.

A. Poverty and Economic Vulnerability in the Extreme

Aged Blacks are among the most economically-deprived groups in our society, no matter what standard of measurement is used. One out of every three Blacks 65 years or older is poor. An aged person was considered poor in 1985 under the Census Bureau definition if his or her annual income fell below $5.156 ($6,503 for an elderly couple). This translates to just $99 per week ($125 for an aged couple) to pay for housing, food, medical care, transportation, clothing and other everyday necessities.

Today, aged Blacks are three times as likely to be poor as elderly Whites. In 1985, 31.5 percent of all Blacks 65 or older lived in poverty, compared to 11.0 percent of all older Whites. Overall, 717,000 elderly Blacks were classified as poor. Quite often, aged Blacks suffer greater extremes of poverty than other elderly groups.

POVERTY BY RACE FOR PERSONS 65 YEARS OR OLDER

[In thousands]

Race	Total number	Poor	Percent poor
White	24,629	2,698	11.0
Black	2,273	717	31.5
All races	27,322	3,456	12.6

Source: Bureau of the Census, U.S. Department of Commerce.

This, though, is just the tip of the iceberg. Nearly 900,000 more elderly Blacks were "economically vulnerable" in 1985. "Economically vulnerable" means that an individual has an income between the poverty line and twice the poverty line (about $10,300 for an older individual and $13,000 for an elderly couple in 1985). The bottom line is that seven out of ten older Blacks are either poor or economically vulnerable.

ECONOMIC VULNERABILITY BY RACE FOR PERSONS 65 YEARS OR OLDER IN 1985

[In thousands]

Race	Total number	Poor and economically vulnerable	Percent poor and economically vulnerable
All	27,322	11,479	42.0
White	24,629	9,729	39.5
Black	2,273	1,615	71.1

Source: Bureau of Census, U.S. Department of Commerce.

The situation is especially precarious for single elderly Black women (individuals living in single-person households or with nonrelatives). About seven out of every eight (87.9 percent) are either poor or economically vulnerable.

Unrelated Black women 65 years or older who were either poor or economically vulnerable in 1985

[In thousands]

Total number	578
Poor of economically vulnerable	508
Percent poor or economically vulnerable	87.9

Source: Bureau of the Census, U.S. Department of Commerce.

B. Income

Inadequate income in retirement is the number one problem for older Blacks. No other problem looms as large as the retirement income crisis which already affects many aged Blacks and threatens to engulf others. Inadequate income is one of the root causes for virtually every problem confronting elderly Blacks, whether it is poor health, an inappropriate diet, dilapidated housing or others.

Congressman George W. Crockett, Jr. (D–MI) summed up the dilemma very appropriately at the NCBA forum in Harlem, when he said:

> In short, nearly every aspect of older Blacks' lives is different from the average situation of older Whites because older Blacks do not have as much money.

If we are to do anything in the long term to improve the living conditions of older Blacks, to improve their health, their incomes, their safety, we must change the dismal statistics of their income, and those statistics are dismal.[1]

The facts demonstrate beyond any doubt that aged Blacks must live on significantly less income than older Whites. In 1985, the median income for aged Blacks was approximately 60 percent of that for elderly Whites.

MEDIAN INCOME FOR BLACKS AND WHITES 65 YEARS OR OLDER IN 1985

Sex	Black	White	Percent Black to White
Males	$6,490	$11,439	56.7
Females	4,441	6,571	67.6
Both	4,925	8,264	59.6

Source: Bureau of the Census, U.S. Department of Commerce

Moreover, older Blacks are much more likely to experience greater extremes of deprivation. Aged Blacks, for example, were nearly twice as likely as elderly Whites to have annual incomes below $3,000, $5,000, or $10,000 in 1985.

[In percent]

	Under $3,000		Under $5,000		Under $10,000	
	Blacks	Whites	Blacks	Whites	Blacks	Whites
Males	6.6	3.1	31.7	11.2	76.6	42.6
Females	17.0	10.9	64.9	34.0	90.8	71.1
Both	12.8	7.7	51.7	24.6	85.2	59.3

Source: Bureau of the Census, Department of Commerce

In fact, five out of every eight (64.9 percent) aged Black females had an annual income below $5,000 in 1985, and one out of six (17.0 percent) had less than $3,000. A large proportion of elderly Black males are also living "on the edge," although the percentage is not as high as for aged Black females. One out of three (31.7 percent) Black men 65 years or older had incomes under $5,000 in 1985, and one out of fifteen (6.6 percent) had less than $3,000.

Poverty is frequently a transitory state for many poor persons in the United States. Many younger poor persons move off the poverty rolls when they find employment or marry. But, opportunities to work or marry are very limited for older Americans. Consequently, low-income elderly individuals are much more likely than other impoverished persons to be locked into a wretched existence for many years or until they die.

Ronald F. Pollack, Executive Director for the Villers Foundation, pointed out at the Harlem forum.

Although the aged make up only 12 percent of the population, they make up 35 percent of the chronic poor. People who

[1] Opening statement at Harlem forum on "Income and Employment Needs of Older Blacks," Oct. 23, 1986, p. 8.

specialize in dealing with questions pertaining to poverty tell us there are two general ways that people come out of poverty.

One is by getting a job. Another is be getting married . . . Those two strategies do not tend to be particularly available for lower-income seniors.[2]

C. Sources of Support

Social Security is the primary source of support for older Americans. More than 90 percent of all persons 65 or older receive Social Security. Of this total, 62 percent of all beneficiaries depend upon Social Security for more than half of their support. Social Security provides nearly all the income—90 percent or more of total support—for 24 percent of all beneficiaries. It provides 100 percent of the support for 14 percent of Social Security beneficiaries.

Overall, Social Security provides 38 percent of the income for persons 65 or older. Other major sources include income from assets (28 percent), earnings (16 percent), government employee pensions (7 percent), private pensions (6 percent), and other income, such as Supplemental Security Income (5 percent). These figures are somewhat skewed because some affluent older Americans derive substantial income from assets, earnings, and private pensions. This tends to inflate the importance of these sources of support for the aged population in general.

Social Security is obviously a key source of support for most older Americans, regardless of race. However, Social Security tends to be more important for aged Blacks because they are less likely than elderly Whites to receive income by assets or pensions.

The proportion of older Blacks receiving Social Security is less than that for aged Whites. However, Social Security constitutes a greater proportion of the income for Blacks 65 years or older than it does for elderly Whites. One important reason is that some elderly Blacks—especially the very old—worked in occupations which were not covered by Social Security or were only partially covered during their working years.

The following tables show that average monthly Social Security benefits for Blacks tend to be about 75 to 85 percent of the amount received from similarly-situated Whites. The disparity would be even greater if Social Security's benefit formula were not weighted to provide greater wage replacement for workers with a history of low earnings.

SOCIAL SECURITY BENEFITS IN 1983 FOR BLACKS, WHITES, AND OTHER RACES

	Number	Average benefit
RETIREMENT INSURANCE		
Retired male wokers:		
Black	857,060	411.00
White	10,313,283	503.00
Other	188,014	436.00
Ratio: Black to white benefits (percent)		81.7

[2] Testimony at Harlem forum on "Income and Employment Needs of Older Blacks," Oct. 23, 1986, p. 36.

SOCIAL SECURITY BENEFITS IN 1983 FOR BLACKS, WHITES, AND OTHER RACES—Continued

	Number	Average benefit
Retired female workers:		
Black	815,000	317.00
White	9,135,316	386.00
Other	110,190	345.00
Ratio: Black to white benefits (percent)		82.1
Spouses of retired workers:		
Black	162,000	174.00
White	2,826,000	230.00
Other	51,000	177.00
Ratio: Black to white benefits (percent)		75.7
Children:		
Black	95,000	149.00
White	385,000	186.00
Other	32,000	127.00
Ratio: Black to white benefits (percent)		80.1
DISABILITY INSURANCE		
Disabled male workers:		
Black	256,701	442.00
White	1,437,488	515.00
Other	36,758	445.00
Ratio: Black to white benefits (percent)		85.8
Disabled female workers:		
Black	141,000	328.00
White	681,000	367.00
Other	17,000	340.00
Ratio: Black to white benefits (percent)		89.4
Spouses of disabled workers:		
Black	43,000	108.00
White	256,000	134.00
Other	9,000	102.00
Ratio: Black to white benefits (percent)		80.6
Children:		
Black	192,000	119.00
White	712,000	141.00
Other	33,000	103.00
Ratio: Black to white benefits (percent)		84.4
SURVIVORS INSURANCE		
Widows and widowers:		
Black	346,000	312.00
White	4,299,000	404.00
Other	49,000	332.00
Ratio: Black to white benefits (percent)		77.2
Widowed mothers and fathers:		
Black	80,000	256.00
White	303,000	327.00
Other	17,000	241.00
Ratio: Black to white benefits (percent)		78.3
Disabled widow(er)s:		
Black	18,702	209.00
White	91,181	259.00
Other	1,708	223.00
Ratio: Black to white benefits (percent)		80.7
Parents:		
Black	2,000	317.00
White	9,000	358.00
Other	1,000	323.00
Ratio: Black to white benefits (percent)		88.5
Children:		
Black	448,000	251.00
White	1,617,000	314.00
Other	80,000	237.00

SOCIAL SECURITY BENEFITS IN 1983 FOR BLACKS, WHITES, AND OTHER RACES—Continued

	Number	Average benefit
Ratio: Black to white benefits (percent)		79.9

Figures are for the end of 1983.

Note: Figures may not total because of rounding.

Source: Social Security Administration, U.S. Department of Health and Human Services.

About 92 percent of all White persons 65 or older received Social Security in 1984, including 5 percent who collected both Social Security and SSI. This compares to 86 percent for aged Blacks, including 19 percent who received both Social Security and SSI. The high proportion of dual Social Security and SSI beneficiaries—about one out of every five aged Blacks—provides further compelling evidence that a significant proportion of aged Blacks receive low monthly Social Security benefits.

PERCENT OF PERSONS 65 YEARS OR OLDER RECEIVING SOCIAL SECURITY OR SSI IN 1984

	Total	Blacks	Whites
Social Security Without SSI	85	67	87
SSI	8	25	6
With Social Security	(6)	(19)	(5)
Without Social Security	(2)	(7)	(1)
Receives neither Social Security nor SSI	7	8	7

Note: Figures may not total because of rounding.

Source: Social Security Administration, U.S. Department of Health and Human Services.

Aged Whites are substantially more likely to receive private pensions than elderly Blacks. In 1984, older White males were 70 percent more likely to receive a private pension than aged Black males. Elderly White females were more than twice as likely to receive a private pension than older Black females.

Lisle C. Carter, Jr.—a former member of the President's Commission on Pension Policy and now a member of the Verner, Lippfert, Bernhard, McPherson and Hand law firm—summed up the situation well in his written statement for the Harlem forum:

> . . . The stark facts are that in 1984, as compared to 34% of all White men who were over 65 years of age, 20% of Black men, 12% of White women and only 5% of elderly Black women received income from a private pension plan.[3]

One important reason that pension coverage is so low for elderly Blacks is because a large proportion worked in jobs not traditionally providing pensions for workers. This is particularly true for older women who worked in low pay and low status employment during their younger years or prior to retirement.

The NAACP Legal Defense and Education Fund made this point emphatically:

> Many older Black women continue working or re-enter the labor force in their later years. Black women between the ages of 55 and 64 comprised 21 percent of all black women em-

[3] Written statement for Harlem forum on Income and Employment Needs of Older Blacks, Oct. 23, 1986, p. 1.

ployed as service workers in 1982. Even after age 65 a Black woman's representation in household and service employment remains high: 41 percent of all Black women employed as private household workers were 65 or older; and 28 percent of all Black women employed as service workers were 65 and older. *Almost half of all elderly Black women have income below the poverty levels.*[4]

D. Employment

As persons reach their late 50's, several clearly discernible and disturbing trends become evident for older workers:

—Their labor force participation rate falls;

—Unemployment may rise;

—Occupational mobility becomes more limited; and

—Poverty begins to increase.

These problems are intensified for aged Black workers. They are much more likely than older Whites to be unemployed, underemployed, or work in lower-paying jobs.

In 1985, for example, older Blacks were 1.8 to 2.4 times more likely to be unemployed as aged Whites. This disparity was sharpest for elderly Black and White males. The unemployment rate was nearly twice as great for Black males 55 to 64 years old compared to White males in the same age group: 7.9 percent vs. 4.0 percent. Black males 65 years or older had an unemployment rate that was 3.3 times the level for aged White males: 8.9 percent vs. 2.7 percent.

1985 UNEMPLOYMENT RATES AMONG INDIVIDUALS 65 YEARS OR OLDER BY RACE AND SEX

	55 to 64 years old	65 years or older
Both sexes:		
Black	7.0	7.0
White	4.0	2.9
Ratio: Black to white	1.8	2.4
Males:		
Black	7.9	8.9
White	4.0	2.7
Ratio: Black to white	2.0	3.3
Females:		
Black	6.0	5.2
White	4.1	3.1
Ratio: Black to white	1.5	1.7

Source: Bureau of Labor Statistics, U.S. Department of Labor.

Older Blacks who are able to work typically earn less than aged Whites who are employed. This pattern is most striking among Black and White males 55 years or older. The median weekly earnings for a full-time wage earner amounted to $323.77 for Black males 55 or older in 1985, compared to $477.58 for aged White

[4] Written Testimony of the NAACP Legal Defense and Educational Fund, Inc. Black Women's Employment Program on S. 1784, The Retirement Income Policy Act, submitted to the Subcommittee on Savings, Pensions, and Investment Policy, Senate Committee on Finance, Feb. 10, 1986, p. 12.

males. This represents just 67.8 percent of the median usual earnings for older Whites. It was as low as 55.6 percent for Black males 65 and above.

The disparity was not as great for Black and White females 55 and above. However, the median usual weekly earnings for a full-time wage earner remains low for both Black and white females: $243.15 a week ($12,643.80 per year) for Black females 55 or older and $285.79 a week ($14,861.08 annually) for aged White females.

MEDIAN USUAL WEEKLY EARNINGS FOR A FULL-TIME WAGE EARNER IN 1985 BY RACE AND SEX

	Black	White	Black percent of white earnings
Males:			
55+	$323.77	$477.58	67.8
55 to 64	327.18	483.63	67.7
65+	222.31	399.53	55.6
Females:			
55+	243.15	285.79	85.1
55 to 64	244.86	289.68	84.5
65+	231.26	244.92	94.4

Source: Bureau of Labor Statistics, U.S. Department of Labor

II. THE BROOKLYN AND THE HARLEM FORUMS

Recent improvements in the overall poverty picture for the aged have created a general impression in some quarters that the elderly are living quite comfortably. Some "so-called" authorities even claim that persons 65 or older are living better than the rest of the population. A careful analysis, through, reveals that these claims are either inaccurate or grossly misleading. In fact, persons 65 or older have the highest poverty rate among adults. Only young people and children—persons 21 or under—have a higher poverty rate than individuals 65 or older.

POVERTY BY AGE IN 1985

[In thousands]

Age group	Total number	Poor	Percent poor
21 years or under	77,677	15,549	20.0
22 to 44	86,871	9,823	11.3
45 to 54	22,662	1,911	8.4
55 to 59	11,212	1,103	9.8
60 to 64	10,849	1,222	11.3
65+	27,322	3,456	12.6

Source: Bureau of the Census, U.S. Department of Commerce

Moreover, the number of poor persons 65 years or older actually increased by 126,000 in 1985, from 3,330,000 in 1984 to 3,456,000 in 1985. Poverty also rose for individuals 60 to 64 years old, from 1,167,000 to 1,222,000. In 1985, only persons 60 to 64 years old and those 65 or older experienced an increase in poverty. All other age groups reported a decline in the number of poor persons. Overall, the number of impoverished Americans dropped by 819,000 for in-

dividuals under 60 years of age, but rose by 181,000 for those 60 or older.

A major reason for conducting the nationwide forums and hearings was to respond to the increasing myths about economic conditions for older Americans. In addition, the forums and hearings provided concrete information for a comprehensive assessment of the true state of affairs for aged and aging Blacks in the United States.

A. Elderly Witnesses and Members of Congress

Congressman Charles B. Rangel (D-NY) described in his written opening statement for the Harlem forum the very difficult decisions that aged Blacks encounter when they struggle on limited income:

> This proceeding and earlier forums sponsored by NCBA will demonstrate beyond any reasonable doubt—even for the most skeptical doubting Thomases—that elderly Blacks have difficult daily decisions:
> —Do they buy food for the table with their limited income or do they purchase badly needed drugs?
> —Which is the greatest priority need for their inadequate income—eyeglasses, hearing aids, dentures, or other services or equipment not covered by Medicare?
> —How are they going to scrape together the necessary cash to meet their initial $520 payment if they are hospitalized next year? [5]

The leadoff elderly witness at the Harlem forum was Baron A. Wilson, a former comedian who earned $1,000 a week during the 1940's. He had roles in several movies ("Death Wish" and "The Wiz"), plays ("Pajama Game" and "Pops Williams"), and television programs ("Edge of Night" and "Secret Storm"), but had come upon hard times later in life. He is now living on about $550 a month ($370 in Social Security benefits and $180 in Supplemental Security Income) at the age of 69. During his peak earning years, he was not covered by Social Security because he worked in Canada. In addition, he was self-employed at a time when these individuals did not pay Social Security tax.

Mr. Wilson may have lost much of his income, but he still retained his clever sense of humor. He described the drains upon the income of senior citizens with some levity:

> Income: food is so high, it is cheaper to eat money, They arrested a little old lady in a supermarket. She had stolen $200 worth of food. They found it in her pocketbook.[6]

Florence H. Rice, a former garment worker, described the drama of living on just $307 a month. She said:

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[5] Opening written statment at Harlem forum on "Income and Employment Needs of Older Blacks," Oct. 23, 1986, p. 2.

[6] Testimony at Harlem forum on "Income Employment Needs of Older Blacks," Oct. 23, 1986, pp. 13-14.

> I live on $307 a month, of which $217 of that goes into rent. Medical, I don't have any of that. I can't afford that. It is certainly too expensive.
>
> Some will say "Why don't you get SSI?" I don't intend to subject myself to the humiliation and insults that we have to be subjected in order to collect SSI.[7]

Seniors at the Brooklyn forum also provided moving accounts about their "triple jeopardy" because they were old, Black and poor. Congressman Edolphus Towns (D-NY) described the economic situation of such services aptly when he said in his opening statement:

> It is a fact that nearly one out of every two Blacks 65 years or older either lives in poverty or so close to it that it really is impossible to tell the difference. I hope this hearing will serve to wake up the American public to the seriousness facing all Black Americans.[8]

Harriett A. Moore, an older outreach worker for the Hugh Ed Gilroy Senior Center, described her volunteer activities with senior citizens. She said:

> . . . Most of the elderly I see live near or at the poverty level. They live in inadequate housing and in high crime areas.
>
> Many seniors are not qualified to receive Medicaid and, having no pensions or health insurance, must make the choice between food and prescription drugs. They cannot afford home attendance, and many are too frail to cook or shop for themselves. As a result, they suffer from poor nutrition.
>
> Often they are on . . . waiting lists because there are not enough meals on wheels for the various communities.[9]

B. Professionals and Leaders in the Field of Aging

Professionals and leaders in the field of aging painted an equally grim picture about the general economic state of many elderly Blacks. New York Assemblyman Roger L. Green (57th District) emphasized that low-income seniors in his district could no longer afford decent housing:

> Today we find increasingly that resources . . . that should be directed toward the upliftment of human beings within our communities are increasingly being targeted to the military budget. In my district, we have an 18-year waiting list for public housing. This has a dramatic impact on the lack of housing afforded elderly persons within my district.
>
> The increased displacement as a result of gentrification within my district and in other areas of this state has increasingly forced seniors into a predicament in which they no longer have decent and affordable housing.[10]

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[7] Testimony at Harlem forum on "Income and Employment Needs of Older Blacks", Oct. 23, 1986, pp. 24-25.
[8] Opening statement at Brooklyn forum on "Income and Employment Needs of Older Blacks", Sept. 12, 1986, pp. 7-8.
[9] Testimony at Brooklyn forum on "Income and Employment Needs of Older Blacks", Sept. 12, 1986, pp. 75-76.
[10] Testimony at Brooklyn forum on "Income and Employment Needs of Older Blacks", Sept. 12, 1986, p. 53.

Roberta Spohn, Deputy Commissioner for the New York City Department for the Aging, provided a comprehensive overview about income and employment characteristics of aged Blacks. She noted that 1.3 million persons in New York City are 60 years or older. Nearly one out of every five residents 65 years or older in New York City is a member of a minority group.

Spohn also emphasized that many older disadvantaged workers are grasping for Social Security before age 65 as a last resort because they cannot locate employment. The net impact is that large numbers are "retiring" early, all too often involuntairly.

> This, of course, will insure that as you get older, if you begin with Social Security at a reduced pension, . . . you are going to be poorer for the rest of your life.[11]

Congressman Owens agreed fully that a large proportion of aged Blacks retire "early" because they cannot find employment. He added:

> . . . In many cases, Blacks retire earlier because they rather say they are retired than unemployed. Many Blacks retire earlier because they can't find work.[12]

III. RECOMMENDATIONS

Inadequate income in retirement is the number one dilemma for older Blacks today. Nearly every other major problem affecting elderly Blacks—such as unfit housing, a shorter live expectancy, improper diet, and others—is related in one form or another to insufficient income.

Far too many aged Blacks and other older Americans now live their final years in deprivation and despair. One of the hallmarks of a great nation is the compassion and respect shown to its seniors. The latter years of life can and should be a time of hope and fulfillment.

A nation as powerful as the United States clearly has the capacity to assure that its senior citizens can live in dignity and self-respect. What is needed is commitment and an action plan.

NCBA has several recommendations. Some of the proposals should be adopted immediately. Others may require lead-in time before they can be approved. All these proposals are crucial for developing a sound and sensible strategy to improve the economic well-being of older Blacks.

Abolish Poverty

First and foremost, our nation should take steps as soon as possible to abolish poverty for all older Americans. NCBA recommends that the federal Supplemental Security Income standards be raised above the poverty lines.

Currently, the maximum federal SSI payment is $340 a month ($4,080 a year) for a qualifying aged individual and $510 a month

[11] Testimony at Brooklyn forum on "Income and Employment Needs of Older Blacks", Sept. 12, 1986, pp. 22-23.

[12] Statement at Brooklyn forum on "Income and Employment Needs of Older Blacks", Sept. 12, 1986, pp. 39.

($6,120 annually) for an eligible couple. Poverty could basically be abolished (using 1986 dollars) if the SSI benefit standard would be increased by slightly more than $100 a month for qualifying individuals (approximately $50 more per month for eligible couples).

1986 POVERTY THRESHOLDS AND SSI MAXIMUM PAYMENT LEVELS OR INDIVIDUALS AND COUPLES WITH NO COUNTABLE INCOME

	Maximum annual SSI payments	Poverty thresholds	Maximum annual SSI payments as a percent poverty thresholds
Aged individual	$4,032	$5,740	77
Elderly couple	6,048	6,600	92

Source: Social Security Administration, U.S. Department of Health and Human Services

States can supplement the federal SSI payments. However, only 26 states and the District of Columbia do so. The median state supplemental payment is $36 per month. In only four states—Alaska, California, Connecticut, and Massachusetts—does the combined federal SSI payment and the state supplement exceed the poverty line.

NCBA recommends that the following actions be taken:

1. The federal SSI maximum payment levels should be raised as soon as possible above the official poverty lines.
2. This measure should be financed by recapturing windfalls provided in the estate tax under the 1981 Economic Recovery Tax Act. These measures largely benefited the most affluent families in our society.

Repeal SSI One-Third Reduction Provision

The SSI benefit standards should not be reduced by one-third when aged, blind, or disabled recipients live in the household of another for a full month and receive in-kind maintenance and support. This provision discourages families from helping other relatives. In addition, it may cause some low-income elderly persons to be unnecessarily or prematurely institutionalized.

Increase SSI Resource Ceilings

The SSI countable resource limitations—currently $1,800 for individuals and $2,700 for eligible couples—will ultimately reach $2,000 for single persons and $3,000 for couples by 1989. When SSI was first enacted in 1972, the countable asset caps were fixed at $1,500 for individuals and $2,000 for couples. Those levels were low then. Today, the resource ceilings have been greatly eroded by inflation. NCBA urges that the countable asset ceilings be raised to compensate for inflation since the program began.

Personal Needs Allowance

Another casualty of inflation is the $25 personal needs allowance for SSI recipients who are in Medicaid institutions, such as an ex-

tended care facility or nursing home. This personal needs allowance should also be updated to compensate for rising prices.

Greater Outreach

Only about one out of every three aged households with incomes below the poverty lines actually receives SSI. In part, this is because the income standards are below the poverty thresholds. In addition, many older persons mistakenly believe that they are not eligible for SSI. The Social Security Administration should conduct outreach projects to assure that more elderly Blacks and other low-income persons receives the SSI benefits to which they are legitimately entitled.

Insulate Social Security and SSI From Cutbacks

Social Security and SSI are and will continue to be primary sources of support for the aged poor in the years ahead. Congress should continue to take the lead in assuring that these programs are not reduced because Social Security and SSI are so vitally important for low-income elderly persons.

Social Security, for example, keeps 9.4 million older Americans off the poverty rolls. If there were no Social Security program, the poverty rate for persons 65 years or older would nearly quadruple.

Repeal Provision to Increase Age for Full Benefits

The provision in the 1983 Social Security Amendments boosting the eligibility age for full benefits from 65 to 67 in the next century should be repealed. This measure will work to the disadvanage of Blacks and other minorities because they have a shorter life expectancy than Whites. It will have another negative impact because the actuarial reduction for persons who must receive Social Security benefits at an earlier age will be even greater than under present law. This could pose a serious hardship for aged Blacks whose health status is not sufficiently severe to meet the strict Social Security disability definition. They may be forced to collect Social Security at age 62 to 63 because they can work only sporadically or not at all. Yet, the actual reduction in their benefits may make it impossible for them to live decently.

Special Elderly Consumer Price Index

A special Consumer Price Index (CPI) for older Americans should be created to measure more precisely the impact of rising prices upon Social Security and SSI beneficiaries. All Americans are affected by inflation, but the effect may vary because of different spending patterns. For example, older Americans spend proportionately more of their income on medical care than younger persons, even with the valuable protection that Medicare provides to them. A special CPI for the aged would be a more accurate barometer for computing cost-of-living adjustments for older Americans who receive Social Security and SSI.

Mandatory Pension Plans

A mandatory pension system should be established along the lines recommended by the President's Commission on Pension Policy—to assure that all workers receive at least a minimum pension.

Limited pension coverage is a major reason that about one out of every three aged Blacks lives in poverty. Older Americans with pension coverage have a significantly lower poverty rate than persons 65 or older who do not have a private or government pension.

Earlier Vesting of Pension Benefits

Pension benefits for workers should vest after three years of covered employment. The 1986 Tax Reform Act strengthened vesting provisions for employers covered by private pension plans. Beginning in 1988, private employees in qualified pension plans must become (1) fully vested after five years or (2) twenty percent vested after three years' employment with gradual increases until full vesting is achieved after seven years.

These changes represent positive developments, but they do not go far enough, particularly for women. The Women's Equity Action League reports that the median number of years of employment for woman workers is 3.1 (5.1 for men). Thus, a large proportion of female and male employees will not earn pension coverage even after the new vesting schedule mandated by the 1986 Tax Reform Act becomes effective. The law should again be modified to provide for full vesting after three years' employment.

Continuation and Expansion of Senior Employment Program

The Senior Community Service Employment Program (SCSEP) should be continued for at least three years with increased funding authority when the Congress considers the 1987 Older Americans Act Amendments. Additional funding can enable more low-income aged Blacks and other persons 55 or older to help themselves while helping others in their communities at the same time. The SCSEP should continue to place great emphasis on employing elderly minority groups.

Senior Environmental Employment Program (SEE)

Congress should provide a line-item appropriation for the Senior Environmental Employment Program (SEE). SEE has proved to be an effective program. It should be continued and expanded so that more older Americans can participate. SEE not only improves our environment but provides meaningful and fulfilling employment opportunities for older workers.

SEE-prototype programs should be established at other government agencies to tap the wealth of experience and talent which elderly persons possess in great abundance. The SEE program has proved to be a cost-effective means for the Environmental Protection Agency to meet its responsibilities under present law by utilizing older Americans. Other government agencies can build upon this already successful venture.

AGE DISCRIMINATION IN EMPLOYMENT ACT

The 1986 Age Discrimination in Employment Act (ADEA) Amendments abolished mandatory retirement for nearly all covered workers in the private sector. Currently, the law covers employers with 20 or more employees. ADEA coverage should be expanded to include employers with 15 or more employees, with the ultimate goal of universal coverage. This will have the effect of broadening the ban on mandatory retirement. It will also help to assure that functional capacity will determine whether an older person is hired, fired, promoted, or demoted.

CHAPTER II: HEALTH NEEDS OF OLDER BLACKS

I. INTRODUCTION

The plight of the Black aged is manifested in many ways. Undoubtedly, one of the most striking examples is the significantly shorter life expectancy for Blacks than Whites. In fact, life expectancy is 6.6 years longer for White males than Black males: 71.5 years versus 64.9 years for males born in 1982. Similarly, White females can expect to live, on the average, 5.3 years longer than Black females: 78.8 years compared to 73.5 years.

A. Detroit, Memphis and Washington, D.C. Hearings and Atlanta Forum

The NCBA forum in Atlanta and the three House Select Committee on Aging hearings (in Detroit, Memphis, and Washington, D.C.) all documented the severity of the health care needs of aged Blacks. Witnesses provided powerful testimony that a health crisis afflicts hundreds of thousands of Blacks 65 years or older. Several authorities also stressed that aged Blacks suffer more intense health problems than other older Americans.

This chapter on Health Needs of Older Blacks draws upon the thorough and well documented testimony presented at the three House Select Committee on Aging hearings and the NCBA forum:

Site and subject	Date
Detroit: Health care problems of the black aged	Mar. 21, 1986.
Memphis: In-home services issues affecting older Americans	May 19, 1986.
Atlanta: Health and long-term care needs of older blacks	Sept. 26, 1987.
Washington, DC: The plight of the black elderly	Oct. 3, 1986.

B. Why Health Care Problems for Older Blacks Are Intensified

Erma Henderson, President of the Detroit City Council, provided a perceptive assessment of elderly Black's state of health:

> Overall, the Black elderly suffer more illnesses and die earlier. Compared to Whites, Blacks spend less on health. Elderly Blacks see a doctor less often, receive less preventive care, and are more dependent on self-diagnosis and self-treatment.
>
> They are more likely to have heart disease, strokes, diabetes, high blood pressure, and hypertension. The Black elderly more likely feel sustained unhappiness which makes them susceptibel to mental breakdowns.

In middle age and a little beyond, the death rate for Blacks is twice that for Whites. At birth, Whites are expected to live about 5 years longer than Blacks.[13]

1. INADEQUATE INCOME

Inadequate income was mentioned repeatedly at the forum and hearings as a primary cause for the poorer state of health for aged Blacks, as well as the inferior care that they receive under our health care system.

Erma Henderson stated the problem simply and succinctly when she said:

> Blacks cannot afford the health care that more affluent persons take for granted. Older Blacks live on much less then elderly Whites and have fewer resources of their own for support.
>
> The percentage of elderly White families that receive income from dividends, interest or rent, for example, is more than four times the percentage of elderly Black families with similar resources.
>
> Families headed by elderly Black men are less than half as likely to be receiving a pension as those headed by elderly White men.[14]

The bottom line is that economic deprivation has taken its toll throughout the lives of older Blacks. It has caused, for example, many Blacks to scrimp on their diets. This has produced deteriorating physical conditions and generally poorer health than for aged Whites.

Dr. Beverly Taylor, Director of the Residency Program at the Morehouse Medical School, provided further powerful testimony on this subject at the Atlanta forum:

> Research has clearly shown that the health service utilization is closely associated with ability to pay for the cost of care. For the poor and socially disadvantaged, such as the minority elderly, there is a decreasing likelihood of securing the kinds of health services needed in the later years of life because of fixed income, few pension or retirement health benefit programs, or insurance that they can draw on after retirement.
>
> As a consequence, many are uninsured and often go without much needed health care. In many instances, inability to pay the cost of health care may mean death at an earlier age than would have been the case had health care been affordable.
>
> With the increasing numbers of persons living to advanced old age, and the increasing incidence of poor and socially disadvantage persons who will be among them, the need for a comprehensive health care system that takes into account the plight of the elderly will become increasingly urgent in the years to come.[15]

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[13] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, p. 5.

[14] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21 1986, p. 6.

[15] Testimony at Atlanta forum on "Health and Long-Term Care Needs of Older Blacks", Sept. 26, 1986, pp. 19-2.

2. MORE VULNERABLE TO DISABILITY BECAUSE OF PRIOR WORK

Older Blacks, in general, suffer more disabling or chronic ailments than elderly Whites. Blacks run a much greater risk of being disabled than Whites because Blacks have a tendency to work in more dangerous occupations.

Sidney Rosen, Director of the Detroit Senior Citizens Department, described this problem in his testimony before the House Select Committee on Aging:

> Black people have historically experienced discrimination and racism that served to deny them access to the kind of employment that would have allowed them advantages toward saving for old age and retirement. Black people have long been relegated to the low-paying positions in this society and denied equal access that millions of other Americans took and take for granted.
>
> For Black men, it is an acknowledged fact that their longevity is far behind that of White women, White men, and Black women. And even when they enter old age, their health standards are appreciably below that of White Americans.
>
> It has been the Black male who has held the low paying, dirtiest, most hazardous jobs and are more prone to the serious chronic illnesses related to old age that are compounded as a result of the kind of work performed in [their] more productive years.[16]

3. HIGH COST OF HEALTH CARE

Rapidly rising health care costs have imposed formidable barriers for aged Blacks and other low-income elderly persons. In fact, health care expenses have increased substantially above the overall inflation rate for several years.

The harsh reality is that the aged's direct out-of-pocket costs average 15 percent of their total income. This is essentially the same level that existed prior to enactment of Medicare and Medicaid.

The Villers Foundation reported in its recent study:

> The sad fact is that, because of skyrocketing health care costs and the absence of truly comprehensive insurance coverage, the elderly today spend the same proportion of their incomes on health care as was the case before Medicare and Medicaid were established, two decades ago. In 1984, average out-of-pocket health care costs for the elderly accounted for 15 percent of their income, the same level that existed before Medicare was enacted. Not including nursing home and other long-term care, the average annual out-of-pocket health expenses for the elderly reached $1,055 in 1984—more than three times the average amount ($310) spent by other Americans. Including nursing home costs, the average out-of-pocket health expenses of the elderly reached $1,705 per year.[17]

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[16] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, p. 13.

[17] *On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age*, a report of the Villers Foundation, January 1986, p. 26.

The high cost of health care has placed aged Blacks and other low-income older Americans in a dilemma. The daily decisions of living have often forced elderly Blacks to compromise their health care.

Many now postpone necessary health care until their ailments reach a crisis state, simply because they do not have the money. Unfortunately, the threat of a costly, catastrophic illness is still too much of a reality for aged Blacks and other older Americans.

Sidney Rosen eloquently described this problem and the underlying causes in his testimony:

> Modern medicine in America is a wonderment and has the promise of providing quality care, yet it does not and will not be accessible to all who need it because it is no longer a human service, but a business tied to our market economy.
>
> In the market place of services, it is the ability of the individual to pay for the service rather than the need of the individual.
>
> It is money rather than illness that creates and maintains the health care establishments. For most older people, aging produces increased medical problems, and these medical problems occur at a point in life where the income is fixed.
>
> The choice is often between medical care and/or food and utilities. Unfortunately, older people have been cruelly portrayed as having received a greater portion of the human services Federal dollars than they have a right to.[18]

4. EROSION OF HEALTH CARE PROTECTION

Medicare and Medicaid represented landmark legislative victories for aged Blacks and other low-income elderly persons. But, the protection from these valuable programs has been whittled away in recent years. Medicare deductible and coinsurance charges for hospital and skilled nursing facility care have soared during the 1980's.

A deductible is a front-end payment that older Americans must either meet directly (such as out-of-pocket payments) or indirectly (through private insurance or Medicaid for low-income seniors). Coinsurance charges are additional costs that the elderly must either pay directly or have covered through insurance, Medicaid, or other means.

The Medicare inpatient hospital deductible charge has jumped by 155 percent during the past six years, from $204 in 1981 to $520 in 1987. This steep initial cost can be a formidable, and sometimes an insurmountable, barrier for aged Blacks and other low-income older persons, especially those without private insurance or Medicaid protection.

Hospital coinsurance charges have leaped forward by a similar percentage hike during this same period. For example, the daily coinsurance charge for a person 65 years old who is hospitalized from 61 to 90 days has soared from $51 per day in 1981 to $130 per day in 1987, a 155-percent increase. Older Americans who must draw

[18] *Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, pp. 12-13.*

upon their Medicare lifetime reserve after being in the hospital for more than 90 days are now subject to a $260-day coinsurance charge, compared to $102 in 1981.

The Medicare Part B deductible for physician and other covered services has increased by 25 percent, from $60 in 1981 to $75 now. The annual Part B premium cost for the aged has risen by 86 percent, from $115.20 in 1981 to $214.80 in 1987.

Omnibus Budget Reconciliation bills have also reduced Medicaid protection in recent years. These changes have produced cutbacks in crucial health care services for aged Blacks and other low-income older Americans. Some states, for example, have reduced coverage for prescription drugs, private duty nursing care, eyeglasses, rehabilitation services, dental care, and other services because of reductions in the Federal share of Medicaid costs.

5. WELFARE MEDICINE

Inadequate income is often closely connected with the quality of care that aged Blacks receive. Elderly Blacks have emphasized that they have been victimized by our two-tier health system and its linkage to economic status. They often receive "welfare medicine;" while the more affluent or those with decent company health insurance receive quality care.

Congressman George W. Crokett, Jr. (D–MI), summarized the inextricable relationship between income and quality of care in his opening remarks at the House Select Committee on Aging hearing on "Health Care Problems of the Black Aged":

> Black senior citizens are frequently less healthy than their White peers. Some surveys show that older Blacks spend twice as many days in bed due to illness than older Whites. We are significantly more likely to have chronic diseases that limit our activities. While our oldest Blacks—and by oldest I refer to those 85 and up—tend to live longer than Whites of the same age, most Blacks die much younger than most Whites.
>
> In fact, the life expectancy for Black men is 6.6 years less than for White men. The life expectancy for Black women is 5.3 years less than White women.
>
> Now we know many of the circumstances that lead up to this bleak picture. Being Black in this country almost by definition means having less income than Whites. as we all know too well, the quality of health care a person receives is all too often determined by the amount of money the patient has to pay.
>
> When you couple that shortage of excellent health care with a lifetime of difficult and unhealthy living and/or working conditions and an income that does not lend itself to a nutritious diet, then you begin to see why this generation of Black elders suffers from particularly poor health.[19]

[19] Opening statement at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, p. 4.

6. SMALL PROPORTION OF AGED POOR COVERED BY MEDICAID

A widely held view is that so-called "safety net" programs (such as Medicaid) are available to catch the elderly poor if they should fall. Medicaid is certainly valuable and helpful for low-income seniors who have this protection. Medicaid pays about 13 percent of the aged's health care expenditures ($536 per capita in 1984).

However, the vast majority of poor older Americans do not have Medicaid coverage. The Villers Foundation reported that only 36 percent of the non-institutionalized aged poor have Medicaid protection.

7. GAPS IN COVERAGE

Another commonly held misconception is that Medicare and Medicaid cover virtually all of the aged's health care costs. However, crucial gaps in coverage exist. Medicare, for example, does not cover numerous high priority health care needs of older Americans, including: out-of-hospital prescription drugs, physical checkups, eyeglasses, hearing aids, dentures, custodial nursing home care, homemaker services, and others.

So-called "medi-gap" insurance policies do not typically cover all of these services, or provide marginal coverage. In addition, only 29 percent of the aged poor have private "medi-gap" policies to supplement Medicare protection.

Medicaid protection also has gaping holes in its safety net. This point was made emphatically in the Villers Foundation report, "On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age:"

> States may also use medicaid funds to pay Medicare's part B (Supplemental Medical Insurance) premium for their elderly Medicaid recipients. But 38 states currently decline to do so, for some or all of these recipients.
>
> After the federal share of funding for the Medicaid program was cut back in 1981, many states were forced to reduce coverage for some medical services. Different states chose different categories to cut, but services affected in various states include prescription drugs, dental care, eyeglasses, private duty nursing care, preventive care, and rehabilitation—all services that are of obvious importance to the elderly, and that are not covered by Medicare.
>
> Some states have also established newly restrictive eligibility criteria and ceilings on payments to those with chronically high medical expenses. These restrictions are especially hard on the elderly poor, of course. With no increase in income, they are being forced to shoulder a greater share of the cost of health care—or go without.[20]

C. Diagnostically Related Group (DRG) System

Care for aged Blacks and other older Americans has undergone marked change because of the Diagnostically Related Group (DRG)

[20] On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age," a report of the Villers Foundation, January 1987, p. 42.

prospective payment system, which represents one of the most significant legislative changes for Medicare since its enactment in 1965.

Previously, Medicare reimbursed hospitals based on their reasonable costs in providing services to covered beneficiaries. This was commonly called "retrospective cost-based reimbursement." Critics of this system claimed there were no incentives for hospitals to be cost-conscious because their income was directly related to the amount of services provided to Medicare patients. Thus, built-in pressures existed for hospitals to overtreat and to keep patients hospitalized as long as possible.

However, the 1983 Social Security Amendments substantially altered the incentives for hospitals treating Medicare patients. Public Law 98-21 established a DRG prospective payment system which encourages hospitals to perform fewer services and to move Medicare patients in and out as quickly as possible to boost their profit margin.

Medicare-eligible hosptial paitients are now classified according to 468 diagnostically related groups (DRGs). The grouping takes account of several factors, including the patient's primary diagnosis, the secondary diagnosis, his or her age, the discharge status of the patient, and the primary procedures.

Hospitals are paid at predetermined rates under this prospective method of reimbursement based upon the patient's DRG classification. This system is further refined by applying separate DRG rates, depending upon whether a hospital is located in an urban or rural area. Additionally, DRG rates are adjusted for hospital wage levels in different areas.

Critics contend that the new prospective payment system causes Medicare patients to be discharged prematurely. They further insist that built-in incentives exist to cut the care to maximize hospital profits. This is because hospitals can pocket any surplus if they can provide care for Medicare patient at less than the DRG-predetermined payment. On the other hand, hospitals must assume the loss when the treatment exceeds the DRG payment. Consequently, hospitals are skimping on care, the critics maintain, in order to increase their profit margins.

Problems associated with the DRG system are further compounded because the Health Care Financing Administration (HCFA) requires Professional Review Organizations (PROs) to limit certain procedures to an outpatient setting. These services are covered under the Part B Supplementary Medical Insurance program which typically requires greater cost sharing for Medicare patients than would be the case if the care were provided in a hospital. This may save the program money, but older Americans may need to dig deeper into their pockets to cover more of these charges.

Aging advocates have often argued that many older Americans are simply not good candidates for certain types of outpatient surgery. Yet, they are faced with a "take-it-or-leave-it" proposition. They basically have two choices. They can incur the risk and expense associated with outpatient surgery or forego the surgery.

The bottom line is that aged patients may be victimized by a "double whammy." First, they may receive inadequate care because hospitals have powerful incentives to skimp on services to

maximize their profits. Second, there is the pocketbook issue. Older Americans are exposed to greater out-of-pocket payments because some services, which they reasonably believed Medicare would reimburse, are not covered now. Moreover, the emphasis on outpatient care, as opposed to inpatient care, will require greater patient cost-sharing.

Perhaps the most common problem is that older Americans are being discharged from hospitals "quicker and sicker" with no suitable care after they leave. The bottom line is that they are faced with both quality of care and access problems.

Several experts have concluded that current policies are limiting or denying access to post-acute care of aged hospital inpatients instead of fostering it. The upshot is that post-actute hospital services are frequently not available, and aged hospital patients are being discharged into a "no-care zone." This has placed greater strains on other institutions in our society, such as Area Agencies on Aging which are increasingly called upon to fill in gaps caused by the DRG system.

D. Long-Term Care

Long-term care refers to a wide range of services, including diagnostic, therapeutic, rehabilitation, and maintenance services for people with chronic impairments. These services can be delivered in institutional (such as hospitals, skilled nursing facilities, or intermediate care facilities) and non-institutional (such as the home) settings.

Older Blacks have been underserved by long-term care institutions. Elderly Whites are more than 1.5 times as likely to reside in homes for the aged (this terminology refers essentially to nursing homes but also includes other long-term care facilities): 5.0 percent versus 3.2 percent. At more advanced ages, Whites are almost twice as likely to reside in these facilities. For example, 15.8 percent of White males 85 or older are in homes for the aged, compared to 8.4 percent for Black males in this same age group. Among women 85 years or older, 26.4 percent of White females are in homes for the aged, in contrast to 13.5 percent for Black females.

Several factors account for aged Blacks' lower participation rate in nursing homes and other long-term care facilities:

—Many Blacks simply cannot afford the high cost of nursing care.

—Discrimination, whether covert or overt, still exists, although this practice is prohibited.

—Some facilities, which serve primarily Blacks, are unable to meet fire, safety, and other code requirements because of limited resources.

—Nursing homes are often viewed with suspicion and deep concern by older Blacks because of news accounts about dreadful conditions that exist in some facilities.

II. FORUM AND THE HEARINGS

Testimony at the NCBA forums and the three House Select Committee on Aging field hearings provided a good blend of expert tes-

timony from physicians and other health care providers, professionals in the field of aging, academicians, researchers, and others. In addition, aged Blacks and senior citizen leaders provided forthright accounts to Members of Congress who attended the forums and the House Select Committee on Aging hearings.

The following summary highlights very briefly some of the key points which the witnesses made.

A. The Professionals

Heart disease, cancer, and stroke continue to be the three leading causes of death for all older Americans, including aged Blacks and Whites. These three causes account for about three out of every four deaths among persons 65 or older. However, differences do exist concerning the impact of various diseases upon aged Blacks and Whites.

1. IMPACT OF CERTAIN ILLNESSES UPON AGED BLACKS AND WHITES

Dr. Stephen Blount, Director for the Office of Epidemiology and Biostatistics for the Department of Health in Detroit, gave this comprehensive analysis:

> Heart disease has remained a leading cause of death in the elderly since 1950. Among those 65 and older, 44 out of every 100 deaths in 1978 resulted from heart disease. Women have experienced more substantial reductions in death rates in heart disease than men in the past 35 years. Significant differences exist between Blacks and Whites in the prevalence of various risk factors for cardiovascular disease.
>
> The principal treatable risks for cardiovascular disease among Whites include hypertension, elevated blood cholesterol, cigarette smoking, diabetes mellitus and obesity. Although it has not been demonstrated by research and this points out the fact that very little research at this time is being done on Black populations, we can assume that these same factors for Whites operate for Blacks as well.
>
> Coronary heart disease mortality rates are similar in White and Black men, but are much greater in Black women than in White women over the age of 65. The number of new cases of coronary heart disease may also be increased in Black women over White. Hospital admission records suggest higher rates of sudden death prior to hospitalization among Black men.
>
> Stroke deaths are much more common, about 60 percent more common in Blacks than in Whites, and a greater proportion of Blacks than Whites suffer nonfatal strokes.
>
> Also more common in Blacks is end-stage renal disease or kidney failure, which results from hypertension often exacerbated by diabetes. Both of these conditions, hypertension and diabetes, occur more among the Black population.
>
> Not only are Blacks more likely to develop high blood pressure, Black hypertensives are at a much greater risk for end-stage renal disease than Whites. Stroke mortality has declined, as well. The mortality for coronary heart disease has subsided substantialy for Blacks in the last 15 years. However, substantial differences still exist in cardiovascular disease.

In terms of other risk factors, cigarette smoking is more prevalent among Blacks than Whites, as is diabetes mellitus, diagnosed and undiagnosed, and obesity is more prevalent among Black women.

Each of these factors is in some way amenable to individual and governmental action, and thus speaks to the need for cost-effective health education programs among Blacks, particularly the Black elderly.

Cancer is the second leading cause of death among adults in the United States, including those over 65, and accounts for approximately 20 percent of all deaths among the elderly.

The risk of developing cancer increases with increasing age, and 56 percent of all cancers are diagnosed among persons 65 years and greater.

The multiple and complex health problems faced by the aged serve to complicate the prevention, diagnosis, and treatment of cancer and increase the cancer burden for the Black community, which is particularly high. Some of the things that I presented in the tables indicate various rates of cancer for the elderly here in Detroit. Those are some specifics.

Although Black and White women share the same three leading sites for cancer, breast, lung, and colon, differences exists in the rates between those two groups for these and other cancers.

While elderly White women have a higher number of new cases than Black women for breast cancer, the death rates are quite similar. This fact, combined with the fact that the average size of a breast tumor at diagnosis is greater in Black women than Whites, suggest that elderly Black women breast cancer patients are diagnosed later and die in disproportionate numbers compared to Whites for this most common site of cancer among women.

Large tumors at diagnosis are less successfully treated and most often require more extensive and disfiguring surgery, which can have devastating effects on both the self-image of the woman and the prospects for reemployment.

Incidence rates among elderly Black women are higher for two of the other more common sites of cancer in all elderly women, colon and cancer of the lungs.

Significantly, the incidence rate for invasive cervical cancer is almost 2½ times greater among elderly Black women than among elderly White women. This is notable because of the existence of a reliable and cost-effective-method to screen women for pre-invasive cancer. That method is a pelvic examination and a Pap smear.

Unfortunately, many physicians discontinue routine cervical cancer examinations after menopause, when the risk of disease is actually greater. Studies indicate that elderly Black women are less likely then their White counterparts to have had a cervical cancer examination.[21]

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[21] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, pp. 54-55.

2. DRG AND IMPACT ON BLACK HOSPITALS AND BLACK PATIENTS

Physicians were generally critical—and sometimes sharply critical—of the relatively new DRG prospective payment system. Dr. Cecil R. Jonas, President of the Detroit Medical Society, noted that the DRG system created formidable problems for hospitals serving low-income persons. He said:

> The hospital that seeks to retain admission of care to the inner city usually finds itself left with large dollar amounts of uncompensated care.
>
> The last Black hospital to close, the Kirkwood Hospital, that did so in November, is now in bankruptcy. And part of the reason is clearly defined: because of the problem of length of stay and claims that are now being denied them by the physical committee of the Medicare system.
>
> The hospital is being forced to either acknowledge its mission to the Black aged or adopt a more restrictive method of both admission and length of stay.
>
> The physician, on the other hand, is faced with the problem of a patient who is old and whose health is compounded by years of neglect; who has many chronic illnesses, but who at the same time cannot pay for entry into most of the health care systems we now have.[22]

Dr. Jonas also maintained that the DRG system was unfair for aged Blacks and other elderly poor persons.

> The DRG system and its step-down concept is discriminating against the Black and poor elderly. Nursing homes and home health care agencies are reluctant to take care of these patients because of the problems of reimbursement or lack of reimbursement for services rendered. If patients are taken by these agencies, minimal care is often given. Only those services and procedures *specifically* listed for reimbursement will be given. Too often it has been found that reimbursement is denied because the procedure does not fit under the specified reimbursable description.[23]

B. The Elderly

Aged persons provided direct and moving accounts about the health care problems that they, their family or friends experienced. Additionally, they told Members of the Congressional Black Caucus and other Members of Congress about the difficulties that they encountered in paying for necessary health care services.

1. THE HIGH COST OF HEALTH CARE

Ramon Mendez, a Detroit resident, was forced to take his sickly wife out of a hospital because he was unable to afford the cost. He brought his wife home, where she remained in a wheel chair for a couple of weeks before dying. Mr. Mendez, who was 84 years old,

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[22] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, p. 74.

[23] Testimony at house Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, pp. 78–79.

told the house Select Committee on Aging, "I just had to take her out of the hospital because I couldn't pay. I cannot afford to pay $450 a week." [24]

2. IMPORTANCE OF IN-HOME SERVICES

Older persons repeatedly emphasized the importance of in-home services for themselves, their families, or their friends. Susan C. Bryant, who received in-home services, described the dilemmas for the elderly in the Orange Mound area of Memphis who were not so fortunate:

We have another person that has been sick; is in the hospital now. [There were] three in the family, [including] . . . her sister. She had to wait on them, all three of them, the husband, the wife, and the son, until she got sick. They did not have a homemaker, any kind of assistance to help them take care of these people in their home, because they were not getting any Medicare, any assistance.[25]

Another in-home consumer in Memphis, Marie A. Fort, told the House Select Committee on Aging how a visiting nurse helped to save her life. She also gave a glowing report on the importance of in-home services for her daily living:

> But I want to say in defense of the agency, I had a serious heart attack in July. I had a massive heart attack in July. I was in the hospital a month. When I got home the doctor said I needed to have nursing service because I live alone. I was so proud of the service I received, because I had Home Health Service. They would come out and clean the house for me and cook my food. They would go and buy the food, because I have no one to do this. My daughter works every day from 8 until 5, and when she gets in she is tired and she is not young, she is 54.
>
> The other service was a nursing service. They came out and I want to say to you, my life was saved by that nursing service. In March my doctor gave me a new prescription. I take six kinds of heart medicine. I had the prescription filled at the drugstore, and I was taking it just as he said. But I got so I could not lift my head up off the pillow.
>
> When the nurse came in one morning I kept telling her about how my head was hurting, I could not get my head up. She looked, the medicine was wrong, it was too strong. She called the doctor and the drugstore and the doctor's wife called me and said, don't take any more medicine until the nurse gets there and exchanges it. I want you to know, I was so weak I could hardly walk.[26]

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[24] Testimony at House Select Committee on Aging hearing on "Health Care Problems of the Black Aged", March 21, 1986, p. 46.

[25] Testimony at House Select Committee on Aging hearing on "In-Home Service Issues Affecting Older Americans", May 19, 1986, p. 19.

[26] Testimony at House Select Committee on Aging hearing on "In-Home Services Issues Affecting Older Americans", May 19, 1986, p. 20.

3. BUDGETARY CUTBACKS

A major source of concern among the elderly was the likely effect of budgetary cutbacks on health care services. Many were fearful that their health service would be reduced or eliminated. Some older persons believed that the aged were being unfairly thrust into the front ranks as deficit fighters. Marie A. Fort gave this account:

> . . . We are trying to live. We have a right to live. We have no right to lose our dignity because somebody young grows up under us. We are the cause of the young people being here. I cannot understand the parents of Gramm and Rudman. They must have been adopted children. They must not have any parents or grandparents. They do not have any right to take my tax money.[27]

III. RECOMMENDATIONS

Older Blacks have poorer health than aged Whites by virtually any standard of measurement. More than one-half (55.1 percent) of all Blacks 65 or older consider their health to be poor or just fair, compared to one out of three (31.1 percent) for elderly Whites. Restricted activity days for aged Blacks is nearly 41 percent higher than for older Whites: 43.4 days per year compared to 30.8 days. Older Blacks are confined to a bed, on the average, approximately 58 percent more than aged Whites: 22.3 days versus 14.1 days per year. Perhaps the most readily apparent effect is the significantly shorter life expectancy for Blacks than White.

In many respects, older Blacks have been relegated to a position at the back of the health care bus. Health care providers have often practiced "welfare medicine" on low-income aged Blacks. The quality of care for older Blacks has frequently been compromised under DRG prospective payment system.

Aged Blacks and other older minorities have been shortchanged, to a large degree, by our health care system. Comprehensive changes are necessary to improve the quality and the availability of health care for aged Blacks and other low-income elderly minorities.

Protection Against Further Cutbacks in Medicare

Aged Blacks and other older Americans have been hard hit in the health arena by recent cutbacks. These measures have boosted the elderly's out-of-pocket payments for Medicare deductibles, coinsurance charges, and premiums.

Congress should resist further cutbacks in Medicare protection as a means to strengthen Medicare's financing. The emphasis should be on controlling hospital, doctor, and other health care provider costs.

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[27] Testimony at House Select Committee on Aging hearing on "In-Home Services Issues Affecting Older Americans", May 19, 1986, pp. 20-21.

Protection Against Further Reductions in Medicaid

Medicaid has also been cut sharply in recent years. Low-income aged Blacks have been among the major casualties of these reductions. The reductions have taken many forms—cutbacks in nursing home care, new out-of-pocket payments, and the elimination or reduction of prior benefits.

Congress should not enact further Medicaid reductions. Cost containment should be the primary goal rather than cuts in benefits.

Promote Wellness and Preventive Measures

Our health care system has an institutional bias. To a very large degree, it is crisis-oriented. Hospitalization (45.2 percent) and nursing home care (20.9 percent) are the elderly's top two health care expenditures. Collectively, hospitalization and nursing home care account for about two-thirds of the aged's health care costs.

Unfortunately, our present health care system provides few incentives for preventive measures. The emphasis is on treatment, rather than on preventing or forestalling an illness.

New initiatives should be developed to promote preventive measures to ward off illness and to encourage wellness among the elderly. Educational efforts are needed concerning appropriate lifestyles and a proper diet to enhance the likelihood for healthier living. Further educational efforts are needed concerning the hazards of smoking and excessive alcoholic consumption. Demonstration projects should be funded under Medicare to determine whether coverage of physical checkups would be cost-effective and feasible.

Improve Medicare/National Health Insurance

Practically every Western industrialized nation in the world has a national health insurance program. The United States is nearly unique among industrialized nations in that it does not provide a comprehensive national health insurance program for all of its citizens. Today, the United States lags behind many industrialized nations in terms of life expectancy, infant mortality rate, maternal mortality rate, and other health indices.

The United States does have a limited national health insurance program for older Americans: Medicare. Over the years, Medicare has proved its value and worth for the elderly. Medicare has clearly had a dramatic effect in making health care more readily available for elderly persons. In fact, about one-third of the increase in the life expectancy for persons 65 years or older during the first 75 years of the twentieth century occurred during the ten-year period after Medicare became law (1965–1975).

As a long-term goal, our nation should enact a universal and comprehensive national health insurance program with built-in cost controls. Until this can be achieved, Medicare should be improved by capping out-of-pocket payments for hospital and medical services, as well as closing gaps for crucial health care needs. A well-conceived and properly structured national health insurance program can provide more comprehensive coverage than Medicare and at a reasonable cost.

DRG Prospective Payment System

The new DRG prospective payment system has helped to reduce the health care inflation rate for Medicare. Unfortunately, the prospective payment system has powerful incentives for hospitals to compromise or reduce the quality of care by discharging patients prematurely. Today, far too many elderly Blacks and other older Americans are being discharged from hospitals without any appropriate follow-up care when in-home or other types of services are clearly needed.

Congress should enact appropriate safeguards to assure that the DRG prospective payment system does not compromise the quality of health care.

Community-Based and In-Home Services

Today a sizable proportion of aged individuals are unnecessarily or prematurely institutionalized at a high public cost. In fact, our health care system seems to have a built-in bias toward institutionalization. Experts estimate that 15- to- 40 percent of all nursing home and hospital patients are improperly institutionalized.

In-home health care services should be promoted. Similarly, steps should be taken to establish a comprehensive community-based long-term care system to provide a broad range of service to enable elderly persons to live independently in their homes and to deliver necessary care for those who must eventually be institutionalized.

Ultimately, this system should be incorporated in a comprehensive national health insurance program. Until this can be achieved, Congress should modify Medicare and Medicaid to improve in-home and community-based care.

For example, Medicare's "homebound" and "skilled nursing care" requirements should be eliminated for home health care eligibility. In addition, coverage of homemaker/chore services, adult day, hospice, and ambulatory care should be provided.

Samuel McCrae, representative of the Quitman County Development Corporation, in Marks, Mississippi, provided excellent testimony on this issue:

> The State of Mississippi itself only averages 650 patients for in-home care a month.
>
> Of the 130 agencies, 82 are served by the Mississippi State Department of Public Health. As you note, there is no shortage of agencies providing services but there surely is a gap in access to health services and to service delivery.
>
> For example, on the average the Mississippi Department of Public Health turns down or rejects 75 to 100 persons per month, or 1,000 persons per year. The problem is the inadequacy of the regulation policies and practices of interpretation that place immovable barriers. The regulation requires that a patient must be homebound, under the care of and referred by a physician. What is the yardstick that determines homebound? Confined to the home or bed, inability to give themselves life-sustaining medication, unable to prepare necessary nutrition in fighting the illness or disability.

Second, those that are not under the care of a physician. They are some—and I shall cite a case later—persons that find themselves between the inability to accept access in home services because of illegal restrictions, the absence and/or inability of the family or relatives to provide such care, and the lack of personal financial resources to provide those services.

Too many of our elderly population who are very sick are finding the only resources are nursing homes. In comparison, in-home care services are less expensive, especially to taxpayers, than the care in nursing homes. The services needed for many nursing home residents can best be served in their own home environment.[28]

RESTRUCTURING MEDICARE TO SERVE LONG-TERM CARE NEEDS BETTER

Medicare also needs to be restructured to be more responsive to the chronic conditions which affect so many older Americans today. Dr. Robert Butler, former Director of the National Institute on Aging and a member of NCBA's Board of Directors, said:

Medicare was designed for people of young and middle age when the main threats to financial security arose out of acute illness rather than chronic incapacity. But the health care needs of the elderly population is substantially different from the young adults. A distinguishing characteristic of old age is the likelihood of multiple, simultaneous crises or losses which may be superimposed on chronic illness and anxieties about incapacity and dying. Such a framework, so different from that common in the younger adult, necessarily changes the work of professionals and consequently requires a restructuring of Medicare so that it covers major *geriatric* needs. These needs include community-based services, long-term care, respite care, and counseling and training of the family—the principal caregivers of the at-home elderly.[29]

NCBA strongly endorses Dr. Butler's recommendations to (1) lift the Medicare prohibition against funding preventive and custodial services and (2) develop a long-term care program for older Americans in the community. NCBA further supports Dr. Butler's recommendations for the provision of other necessary services. Dr. Butler's spelled those out in greater detail in his oral presentation:

We have to provide within this restructured Medicare rehabilitation, long-term care, home care, respite care, counseling and training of the families which are, after all, the principal and extraordinary caregivers in our society for older people.[30]

[28] Testimony at House Select Committee on Aging hearing on "In-home Services Issues Affecting Older Americans", May 19, 1986, p. 36.

[29] Prepared statement of Dr. Robert Butler for House Select Committee on Aging hearing on "The Plight of the Black Elderly", October 3, 1986, p. 5 of written statement.

[30] Testimony at House Select Committee on Aging hearing on "The Plight of the Black Elderly", October 3, 1986, p. 26 of transcript.

Improving Accessibility in Long-Term Care Facilities

Historically, older Blacks have been underserved by long-term care institutions. The 1977 National Nursing Home Survey, for example, revealed that only 4 percent of all skilled nursing home residents were Black. On the other hand, White Non-Hispanics represented more than 93 percent of the total. Yet, aged Blacks constitute more than 8 percent for all persons 65 years of older. Older Blacks accounted for 7 percent of all residents in Medicaid intermediate care facilities, which serve low-income chronically imparied persons. However, elderly Blacks represented 22 percent of the total aged poverty population in 1977.

A fundamental objectives of our long-term care policies should be increased accessibility for older Blacks. Strict enforcement of civil rights legislation is absolutely essential. Nursing home ombudsmen under the Older Americans Act should also monitor the situation and report their findings to appropriate officials.

Funding for Research

Funding for disease-related research has proved to be an effective investment for our nation. Research funded and conducted by the National Institutes of Health has helped to extend longevity and the quality of life for older persons.

NCBA strongly supports funding for research to combat diseases affecting the elderly and minorities, including Alzheimer's disease, cancer, heart, stroke, hypertension, and others. NCBA basically believes that Congress has exercised good judgment in providing appropriations for the National Institutes of Health during a period of austerity.

Increased Funding for Black Medical Schools

Aged and younger Blacks are often underserved by our medical system because trained physicians are not located in areas where Blacks may live. Doctors clearly have a tendency to establish their practices in more affluent communities.

Minority physicians often have greater service obligations in sponding to the health care needs of aged poorer and yo Blacks when compared to most other medical school graduat

NCBA strongly believes that a clear need exists to train more Black physicians. Dr. Louis Sullivan, President of the Morehouse Medical School, made an eloquent presentation about the need for additional federal funding for historical Black medical schools. Dr. Sullivan pointed out that only 3 percent of all physicians are Black although Blacks comprise 12 percent of our total population:

> Some of you may not be aware of the fact that it was 1966, some twenty years ago, that the last of the medical schools in the South admitted their first Black students ever. Indeed, until 1948, only thirty-eight years ago, none of the medical schools in this region of the country, one-third of our schools in the nation, admitted any Black students.
>
> It is for these reasons that in 1975 with the leadership from the Black physicians in Georgia and with the support of the white physicians as well, Morehouse College decided to explore

the development of a new, predominantly Black medical school.

The mission of our school is to train a new breed of physicians for service as primary care practitioners to work in medically underserved inner cities and rural areas of our country, areas where a high percentage of the population is poor and from ethnic minorities.[31]

[31] Testimony at Atlanta forum on "Health and Long-Term Care Needs of Older Black", Sept. 26, 1986, p. 12.

CHAPTER III: BUDGET ISSUES AFFECTING OLDER BLACKS

I. INTRODUCTION

Older Americans from all walks of life and all sections of our nation have been hit hard by budgetary cuts in recent years. Yet, many opinion leaders believe that the elderly have escaped virtually unscathed from the budget knife. However, aged Blacks and other older Americans have clearly suffered.

A. Cuts in Benefit Programs

Social Security, which is the major source of support for elderly Blacks and other older individuals, has been cut on a number of occasions during this decade. The most substantial reduction occurred in 1983, when the aged did not receive a cost-of-living adjustment (COLA). The six-month delay in the COLA—from July 1983 to January 1984—cost Social Security beneficiaries an estimated $4.2 billion in lost benefits in fiscal year 1986.

Deductible and other out-of-pocket payments have jumped under Medicare because of budget cuts, spiraling health care costs, and the advent of the new diagnostically related group (DRG) system. The hospital deductible charge—the front-end payment that older Americans must meet from their own resources or other means—has increased by a whopping 155 percent in just six years, from $204 in 1981 to $520 in 1986. (See Chapter on Health Needs of Older Blacks for more detailed information.)

Omnibus Budget Reconciliation bills have reduced Medicaid protection. Aged Blacks have been especially hard hit because they are much more likely to be adversely affected than elderly Whites since Medicaid is a means-tested program. (See Chapter on Health Needs of Older Blacks for additional information.)

General services and housing assistance programs have also been cut back sharply in recent years. Older Blacks are among the major victims of these reductions. They are more likely than other elderly groups to be eligible for these programs since about one out or every three Blacks 65 years or older lives in poverty.

Housing programs have been especially hard hit. Conventional public housing starts, for example, have fallen by 79 percent within a five-year period, from 36,365 in fiscal year 1980 to 7,714 in 1985. About two out of every five households living in public or subsidized housing in fiscal year 1980 were headed by an aged individual. Thus, the substantial reduction in public housing has created serious problems for older Americans, especially elderly Blacks.

The Section 202 housing for the elderly and handicapped program has also been cut back during this decade, although not as sharply as public housing. Section 202 has experienced a 58-percent

decline in housing starts during the past five years, from 20,850 in fiscal year 1980 to 8,753 in 1985.

In addition, tenants in federally-assisted housing are now paying higher rents. One important reason is that public housing and Section 8 tenants can now be charged rent equal to 30 percent of their adjusted income. Prior to 1982, a 25 percent tenant rental payment ceiling existed for these programs.

Several food stamp cutbacks have impacted either directly or indirectly on older Blacks, including:

—Enactment of a less current method to update the thrifty food plan for food stamps; and

—Elimination of a more generous method for deducting medical expenses in computing income for food stamps.

The bottom line is that these measures and others have reduced food stamp benefits in one form or another for aged Blacks.

B. Gramm-Rudman-Hollings Amendment

The Gramm-Rudman-Hollings (GRH) amendment has further intensified the budgetary squeeze for programs serving older Americans and elderly Blacks. The GRH establishes a five-year timetable to balance the budget by Fiscal Year 1991. Annual targets are provided to reduce the deficit until the budget is ultimately balanced: $144 billion in fiscal year 1987, $108 billion in 1988, $72 billion in 1989, $36 billion in 1990, and zero in 1991. A $10-billion leeway is permitted for the mandated deficit target for each year except for 1991 when the budget must be balanced.

An automatic spending reduction procedure (called "sequestering") is provided if Congress and the Administration cannot agree on a budget which conforms to the target amounts. However, several programs are exempted from the sequestering process, including Social Security Supplemental Security Income, Medicaid, food stamps, and veterans pensions and compensation payments.

The automatic spending reduction procedure came into effect in fiscal year 1986, producing a 4.3-percent cut for programs covered by the sequestering process. It produced several negative effects for older Blacks, including the following:

Senior Community Service Employment Program.—Approximately 2,800 positions for low-income older Americans were eliminated under the 4.3-percent automatic spending procedures of the balanced budget amendment. About 23 percent of all Title V SCSEP enrollees are Black. It is estimated that about 650 fewer positions will be available for aged Blacks during the 1986-87 program year.

Nutrition Program for the Elderly.—The Older Americans Act nutrition program for the elderly was cut by $17.4 million under the GRH amendment, reducing the number of meals served by a projected 4.1 million from 1985 to 1986. An estimated 450,000 fewer meals were served to aged Blacks during fiscal year 1986 because of the 4.3-percent cut.

Supportive Services.—Funding for the Older Americans Act Title III-B supportive services program was cut by $11.4 million. On an individual basis, this meant a reduction in a wide range of supportive services for about 400,000 older Americans. An estimated 66,000

fewer Blacks received Title III-B services after the automatic spending reduction became effective.

Housing.—Federally-assisted housing programs were also reduced under the balanced budget amendment. The number of housing units that could be financed under the Section 202 housing for the elderly and handicapped program was trimmed. Originally, the Congress provided sufficient funding for about 21,000 units. Similarly, the number of additional public housing units financed declined.

II. THE PHILADELPHIA FORUM

The Philadelphia forum provided numerous accounts about the effect of budget cutbacks in recent years for aged Blacks. Witnesses raised questions repeatedly about the fairness of the reductions for some of the most disadvantaged persons in our society.

Congressman William H. Gray, III (D-PA), who chaired the forum, and others who attended the proceeding also took strong exception to our nation's priorities. They generally felt that the tax cuts enacted in recent years have largely benefited the wealthy, while doing little for low-income Blacks. They strongly objected to shifting more funding to the military at the expense of domestic programs. And, they vehemently opposed the GRH balanced budget amendment.

A. Budget Out of Control

Another prevalent theme was that the national budget is out of control. Congressman Gray, who chairs the House Budget Committee, noted that the budget deficit had more than doubled since 1980. He said:

> Let me give it to you in clear terms: in 1980, the total debt of America—that's right, the total debt, for two hundred years, all the presidents, from George Washington to Jimmy Carter—the total debt of this nation was $914 billion.
>
> Today as I talk to you, in just over five years, it has been doubled to over $2.1 trillion.
>
> In 1980, those who criticized 40 and 50 billion dollar deficits are now the custodians of a national government that, for the second year in a row, will have deficits of well in excess of $200 billion.[32]

B. Questions of Fairness

Congressman Gray also criticized the fairness of the budgetary cuts. He told the audience that he had "bad news and worse news." The bad news was that the budget deficit was in excess of $200 billion. The worse news, Congressman Gray explained, is that there are proposals to reduce the deficit by cutting programs for older Blacks and other disadvantaged persons in our society. He said:

> Now, if that isn't bad news, let me give you the worse news. The worse news is that, those who gave us all of this debt, the

[32] Opening statement at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, pp. 18-19.

tax cuts for the wealthy, have been suggesting for the last five years that the way to lower the debt is on the backs of those least able to afford the burden in our society, on those who did not benefit from any of the increased federal spending, and on those who have not caused spending to go up.[33]

Congressman Gray emphasized that the House Budget Committee would work for an equitable budget. He added:

> We have maintained current funding levels, and this year we have dramatically increased many of those programs, while at the same time reducing the deficit. Because we believe that you can reduce the sea of red ink, but you don't have to do it on the backs of the elderly, you don't have to do it on the empty stomachs of our children, you don't have to do it by shortchanging the educational opportunity of the next generation.[34]

John Stallworth, National Secretary for the American Association of Retired Persons, gave an inspirational presentation. He clearly captured the mood of the audience when he urged that our budget priorities be reordered:

> I know our officials must give importance to the exploration of unknown space, to defensive armaments to foil unknown enemies, and to the subsidy of soldiers in other countries who have known motives, but what is the big deal in providing ample care for loyal, trusting citizens that are now deprived of youth and income?
>
> We come here because we earned that right and the responsibility to take part in the policy-making procedures that affect our health, our pocketbooks, and our lives. I've been told officials can say no more ways than an unpaid hooker. (Applause)
>
> Please do not let them reduce the benefits to your seniors. AARP tries to see that grace and dignity are given to the aged. It wants government to make some changes in its regulations, business to provide more accountability, and both to have better planning and administration in their programs.[35]

C. Special Problems Encountered by Aged Blacks

Mr. Stallworth further emphasized that older Blacks were raised at a time when widespread discrimination existed in our nation. This has had a profound impact on the economic state of affairs for aged Blacks:

> It has been hard for us Blacks to continue to love our country. But we have. Even when it told us to drink at another fountain, sit on another toilet, go to a different school, and live across the tracks. Now, our faith in its ideals has been justified. Thank God, those things are past. But now that we are

[33] Opening statement at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 19.
[34] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 62.
[35] Opening statement at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 23.

old, should we again be subject to treatment that brings all these frustrations back? Maybe there is such a thing as too much experience.[36]

D. How Budget Cuts Affect Older Blacks

A panel of aged Blacks described in very personal terms how recent budget cuts have affected them, their families, and friends. Johnny L. Williams, a retired government employee, told the panel that cuts or freezes in federal pension benefits made his life more difficult. He said very frankly, "Being cut this way, it hurts not only myself, but also my family, and everyone else." [37]

Abigail V. Pankey, Coordinator for the Tyre Center for Adults, told the panel that funding cuts have hindered programs at her senior center. The center has been able to limp along, though, through fund-raising activities, including contributions from the aged's limited income. She said:

> . . . Our center was funded at one time by the Philadelphia Corporation for the Aged. When the funds were cut and we no longer received any money, our seniors used their money to help their center to survive.[38]

E. Gramm-Rudman-Hollings Amendment

Brian A. Karim, Senior Community Service Employment Program Director for the Philadelphia, PA Mayor's Commission on Aging, discussed the problems caused by the balanced budget amendment. He noted that the number of community service employment positions were reduced as well as the number of people served by the Senior Community Service Employment Program. Mr. Karim gave this account:

> There were cuts through the Gramm-Rudman amendment, and also it is the 1.5 percent cut in the administrative funds that was passed on through the Department of Labor. The administrative funds, of course, are the area or the part of the budget that we have to operate the program.
>
> We experienced about a $38,000 cut in our budget , a large part of that being administrative costs. So what has happened, we had to cut two staff positions, which means we are trying to do the same amount of work with less people, which is difficult.
>
> The second thing we had to cut, we had a cut in our authorized slot level, so that the number of people that we're able to serve, again, is lowered. We have 16 fewer slots, but we have an average of 100 people applying every month. And this is every month for the last two months since July.
>
> So at that current rate of 100 people per month, you know, you figure 1,200 people are going to apply, but yet you've got

[36] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, pp. 61-62.
[37] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 47.
[38] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 50.

fewer slots to serve people. And June and July, or July and August, incidentally, are the slower months.

We have had over 400 people come in looking at our job board. We've had over 700 people call in each month for employment and other types of services offered by the Mayor's Commission on Aging.[39]

C. Clifford Washington, Chairman and President of the Coalition of Advocates for the Rights of the Infirm Elderly, expressed concern that the GRH amendment would adversely affect aged Blacks. Mr. Washington, who is also on the Board of Directors for the National Caucus and Center on Black Aged, Inc., said:

> The Gramm-Rudman [amendment] has the knife, and has . . . many people thinking.
>
> Program cuts affect the poor Black elderly, retrenchment and all of the other things make it pretty bad for them.[40]

III. RECOMMENDATIONS

NCBA's forum in Philadelphia and other studies have made it clear that aged Blacks and other low-income elderly persons have been adversely affected by budget cuts in recent years. In virtually every program serving older Americans, reductions have been enacted into law in one form or another during this decade. The net impact is that large holes exist in safety net programs for low-income elderly persons.

The situation has been intensified with the enactment of the GRH amendment, which has established a five-year timetable for balancing the budget. Programs benefiting older Americans have already been negatively affected by the automatic spending reduction trigger in the balanced budget law.

Balanced Approach to Reducing the Deficit

To a very large degree, our budget deficit is traceable to hefty increases in Pentagon spending and major tax reductions enacted into law in recent years. Military spending has more than doubled during the past seven years, from $134 billion in fiscal year 1980 to $279 billion in 1987.

Sizeable tax cuts have also reduced the revenue base. Moreover, the Internal Revenue Code is filled with gaping loopholes, which enable some of the most affluent people and businesses in America to pay little or no taxes. For example, a study by Citizens for Tax Justice found that 129 out of 275 corporations either paid no taxes or received rebates on prior taxes paid in at least one year during the 1981-84 period. However, these 129 businesses had $66.4 billion in domestic profits during this period.

A more balanced approach is needed to reduce the federal budget deficit. A greater emphasis should be placed on closing loopholes in the tax law. In addition, Congress must search for fair and effective means to reduce spending. Congress must continue to be vigilant in

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[39] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, pp. 78-79.

[40] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 57.

preventing wasteful spending at the Pentagon and other agencies. NCBA urges that every effort be made to avoid cutbacks for programs serving the poor and disadvantaged.

Repeal Gramm-Rudman-Hollings Amendment

Critics of the GRH amendment claim that it places a straightjacket on the government by imposing rigid deficit targets. Moreover, they argue that the GRH amendment can exacerbate an economic downturn by forcing cuts at a time when "pump priming" may be more appropriate.

Supporters of the GRH amendment claim that the automatic spending reduction mechanism is necessary to have an effective enforcement procedure in place.

NCBA believes that Congress should vote cuts in programs on the basis of budgetary considerations and the merits of the particular programs, rather than resorting to a ratification of across-the-board reductions as under the GRH amendment. NCBA further believes that Congress should repeal the GRH amendment and should establish realistic deficit target goals which are voted by the Congress. Additionally, NCBA supports an enforcement mechanism through either the appropriations or budgetary process.

CHAPTER IV: HOUSING ISSUES AFFECTING OLDER BLACKS

I. INTRODUCTION

Our nation has articulated a goal of decent, safe and affordable housing for Americans of all ages since Congressional passage of the Housing Act of 1949. However, older Americans continue to be among the most poorly housed groups in America today, especially elderly Blacks and other low-income aged minorities.

An estimated 20 percent of elderly households reside in inadequate or substandard housing. Housing is the most expensive budget outlay for older Americans. Many elderly persons spend at least one-third of their income for shelter, and a significant percentage spend substantially more—especially low-income aged persons who are unable to live in federally-assisted housing. In fact, almost one-half of the elderly poor spend 45 percent or more of their meager income for shelter.

A. Housing Situation for Older Blacks

Housing is perhaps the most visible sign of deprivation among older Blacks. Elderly Blacks, for example, are 3½ times as likely to be without plumbing for their exclusive use than older whites: 8.4 percent compared to 2.4 percent in 1980.

About three out of seven housing units occupied by aged Blacks lacked central heating in 1980. Older Blacks are almost 2½ times as likely to live in housing without central heating than aged whites: 43.5 percent vs. 18.4 percent.

One out of every 14 aged Blacks lived in housing without a complete kitchen facility in 1980. Elderly Blacks are four times as likely to reside in housing lacking a complete kitchen facility than older Whites: 7.3 percent compared to 1.8 percent.

Aged Blacks are three times as likely as elderly Whites to have no phone in their homes: 12.3 percent vs. 4.1 percent in 1980.

The vast majority of housing occupied by older Blacks did not have air conditioning in 1980. Aged Blacks are 1½ times as likely as older Whites to live in a dwelling without air conditioning: 67.0 percent compared to 44.9 percent.

Today, thousands of older Blacks live in ramshackle, deteriorating or unfit housing. Many find themselves in an impossible housing situation. Their homes may be old, crumbling or deteriorating. Yet, they lack the financial resources or skills to repair their dwellings to make them more habitable.

The problem is further intensified by rising property taxes and maintenance costs. The net impact is that older Blacks are frequently trapped within their present unsuitable living arrangements because appropriate and affordable housing—such as an

apartment, shared housing or other options—are often not available.

About one out of three elderly Blacks found their housing to be unsuitable, according to a 1981 Louis Harris poll commissioned by National Council on the Aging. Among all older Americans, one out of eight persons 65 years old consider housing to be a serious problem.

Most elderly families are homeowners. However, homeownership is much more prevalent among aged Whites than older Blacks. In 1980, 57.8 percent of all households with an aged Black head were owner occupied, and 42.2 percent were renters. This compares to 72.1 percent and 27.9 percent, respectively, for aged Whites.

B. Unavailability of Suitable Housing

As the elderly population grows, the demand for suitable housing to meet their special physical and social needs will continue to increase.

About one out of every nine Americans today is an older American. Demographers are now projecting that one out of five persons in the United States will be 65 years or older by the year 2030, and one out of three will be 55 or older. The "older-elderly"—those persons 85 years or older—will be among the fastest growing age group in our society. Their numbers are expected to triple between now and 2020. This is significant because the older-elderly have specialized housing needs that often vary from the conventional living arrangements for most other Americans.

In fact, a recent University of Michigan study projected that 235,000 new elderly housing units need to be built to keep pace with the anticipated demand. However, federally-assisted housing construction has declined sharply in recent years.

Today, long waiting lists exist for elderly housing. One noteworthy example is that the waiting list for Section 202 housing for the elderly and handicapped has averaged about 13 months in length. Nearly one out of four applicants must wait five years or more before a Section 202 unit becomes available.

Recently, more than a quarter of a million older Americans were on the waiting list to move into Federally-assisted Section 202 housing. Only about 21 percent of the aged applicants, on the average, will move into the housing which they have sought.

This represents just the tip of the iceberg. Long waiting lists also exist for other federally-assisted housing programs. Many elderly Blacks and other older Americans do not apply for housing assistance because they do not believe that they have a realistic chance to be considered, although they may want and need new housing arrangements.

C. Cutbacks in Housing Assistance

The housing problem for aged Blacks and other low-income older minorities has been intensified by the hefty reductions for federally-assisted housing programs in recent years. This has crimped the supply of available, affordable and suitable housing for elderly Blacks and other older Americans.

Housing starts have fallen off by 58 percent for the Section 202 program, from 20,850 in fiscal year 1980 to 8,753 in 1985. Conventional public housing starts have plummeted by 79 percent during this same period, from 36,365 in 1980 to 7,714 in 1985. Aged Blacks and other low-income elderly persons have been victimized by these cuts because about two out of every five households living in public housing is headed by an aged person.

Rental expenses have also jumped for tenants living in Section 8 public housing. As cited previously, they can now be charged 30 percent of their family's monthly adjusted gross income for rent.

Despite the great need for housing for low-income aged Blacks and other older Americans, only 13 percent of all elderly poor persons resided in federally-assisted housing in 1984.

II. NCBA FORUMS AND HOUSE SELECT COMMITTEE ON AGING HEARINGS

Witnesses at the NCBA forums and the House Select Committee on Aging hearings provided much testimony about the seriousness of the housing problem for older Blacks. Respected professionals, such as former U.S. Housing and Urban Development (HUD) Secretary Robert C. Weaver, gave incisive analyses. Elderly Blacks provided personal accounts about the daily trauma of living in unsuitable housing.

The message, though—whether it came from the professional or the senior citizen—was the same: A housing crisis already exists for aged Blacks. It is likely to deteriorate in the years ahead unless policy changes are made.

A. High Cost of Housing

Both senior citizens and professionals in the field of aging considered high costs to be at or near the top of the list of housing problems for aged Blacks. One former International Ladies Garment Workers Union worker, Florence H. Rice, was forced to spend 71 percent of her meager income for rent. She told the panel members who attended the Harlem forum:

> I live on $307 a month, of which $217 of that goes into rent.[41]

Ms. Judith Walker, Commissioner for the Chicago Department of Human Services, emphasized that many low-income older persons were forced to live in crime-infested neighborhoods because they could not find affordable alternative housing. Ms. Walker explained:

> Many of our seniors are in cities or in parts of the cities and they're forced to live in these [areas] because there is no affordable housing. And that isolation makes them more vulnerable to crime than any other segment of our population.[42]

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[41] Testimony at Harlem forum on "Income and Employment Needs of Older Blacks", Oct. 23, 1986, pp. 24-25.

[42] Testimony at Chicago forum on "Crime Against Black Elderly", Aug. 18, 1986, p. 29.

B. Inadequate and Dilapidated Housing

Samuel McCrae, Representative for the Quitman County Development Corporation, told the House Select Committee on Aging at the Memphis hearing that four out of five occupied housing units were substandard in Marks, Mississippi, one of the poorest areas in the United States. Many of these units were occupied by elderly Blacks. Mr. McCrae said:

> Quitman County, MS is listed by the U.S. House Select Committee on Hunger as one of the poorest areas in the Nation. 41.4 percent of the county is below the poverty level, 81.1 percent of the Black inhabitants fall in this dilemma, 20.7 percent officially are unemployed, 80 percent of all occupied housing is substandard and is dilapidated.[43]

C. Budgetary Cutbacks

Former HUD Secretary Robert C. Weaver stated that recent budgetary cuts have aggravated the housing problems for older Blacks. Dr. Weaver gave this sobering account:

> The current situation may be described as follows: more than one-quarter of American households today are unable to secure adequate housing at affordable prices. Low-income senior citizens are among the groups most adversely affected, especially Black low-income senior citizens.
>
> The principal cause of severity of housing problems among the less affluent in general and the elderly less affluent in particular has been the recent trend toward drastic reduction in publicly-assisted housing.
>
> This has occasioned a quantitative reduction of affordable units as well as a qualitative decline in the . . . shelter with special equipment designed to meet special needs. Homeless people and "bag women" on the streets are an ever-present reminder of the housing crisis: their numerical increase is a symptom of the severity of housing problems confronting the poor.[44]

Mr. Weaver said that the prognosis was "bleak". He told the House Select Committee on Aging:

> Yet today, the gap between housing needs and housing assistance remains enormous. Four-fifths of very low income households receive no housing assistance, and it is estimated that at least two-thirds of them face problems of physical inadequacy, crowding, or excessive costs. Some 6 million of the poorest households receive income assistance from welfare but this aid is rarely, if ever, sufficient to assure decent and affordable shelter to the recipients.[45]

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[43] Testimony at House Select Committee on Aging hearing on "In-Home Services Issues Affecting Older Americans", May 19, 1986, p. 35.

[44] Testimony at House Select Committee on Aging hearing on "The Plight of the Black Elderly: A Major Crisis in America", Oct. 3, 1986, pp. 29-30.

[45] Testimony at House Select Committee on Aging hearing on "The Plight of the Black Elderly: A Major Crisis in America", Oct. 3, 1986, p. 30.

Assemblyman Roger L. Green told the Brooklyn forum that some public housing projects had 18-year waiting lists in the district that he represented. He also emphasized that shifting budget priorities and cutbacks had worsened a housing crisis in New York City for low-income seniors. Assemblyman Green said:

> Today we find increasingly that human resources that should be directed toward the upliftment of human beings within our communities are increasingly being targeted to the military budget. In my district, we have an 18-year waiting list for public housing. This has a dramatic impact on the lack of housing afforded elderly within my district.
>
> The increased displacement as a result of gentrification within my district and in other areas of this state has increasingly forced seniors into a predicament in which they no longer have decent and affordable housing.
>
> Nevertheless, we find that we have a national administration that would attempt to build silos for housing missiles as oppose to housing for those who indeed need such as our seniors.[46]

Geneva Black, director of the Haddington Older Adult Center in Philadelphia, said that rent increases and other rising housing costs were playing havoc with the elderly's limited budget. She explained:

> Most of our elderly, again, are living on an income of 380 to 400 dollars a month, and they can no longer afford to live in their own homes—homes that they have struggled and purchased over the years. And that is because of the high utility bills, which is some cases, during the winter months, exceed the monthly income. Therefore, they seek a living arrangement comparable to their needs, supplemental rental units, Section 8.
>
> And now the rent has increased from 25 percent of tenants' income to 30 percent. With 30 percent of their income being paid towards rent, and increasing utility bills, there are many cases where the rent and utilities are exceeding the monthly income.[47]

III. RECOMMENDATIONS

Large numbers of older Blacks are discovering today that they are in a practically impossible housing situation. Rising property taxes and maintenance costs may make it difficult for elderly persons to remain in their homes. Some are physically unable to do the work necessary to maintain a home.

Many older Americans already live in dilapidated housing, especially aged Blacks. Housing problems are further intensified for older Blacks, in large part because they are three times as likely to be poor as aged Whites.

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[46] Testimony at Brooklyn forum on "Income and Employment Needs of Older Blacks", Sept. 12, 1986, pp. 53–54.

[47] Testimony at Philadelphia forum on "Budget Issues Affecting Older Blacks", Sept. 20, 1986, p. 69.

Housing Goals

Delegates at the 1981 White House Conference on Aging made a stirring call for improved housing for older Americans. One of the top prority goals was the provision of 200,000 additional housing units for older Americans per year. A University of Michigan study has projected a similar need (an additional 235,000 units annually).

Our nation should set a goal of at least 200,000 additional housing units per year of older Americans. The public, private for-profit, and voluntary sectors should work cooperatively to implement this goal. At the federal level, there should be an appropriate mix of public housing, Section 8 assistance, Section 202 housing for the elderly and handicapped, and Farmers Home Administration programs to respond to the many and varied housing needs of aged Blacks and other older Americans.

It is crucial that the Section 202 and Section 8 rental assistance programs work in tandem because many elderly Blacks simply cannot afford to pay the rent without the Section 8 subsidy.

Congregate Housing Services

Housing must be more than just bricks and mortar. Quite frequently, shelter must be combined with services to assist older persons to continue to live independently in their own homes. Congress recognizes this clear-cut need in 1978 when it authorized funding on a long term basis for congregate housing services.

The congregate housing services program should continue as an ongoing program, and its budget should be increased. It should also be a cornerstone in our nation's housing strategy to improve the quality of life for "at risk" older persons who could wind up in a nursing home at a significantly higher public expense. Some experts project that 15 to 40 percent of all nursing home residents do not need full institutional care, but simply require basic social services such as meals, housekeeping, or personal care assistance.

Congregate housing services are not only humane but also make sense economically for our nation and older persons. Funds for congregate services activities, for example, can provide a substantial financial dividend by preventing unnecessary or premature institutionalization.

Alternative Housing Arrangements

As persons age, their need for alternative housing arrangements also increases. However, suitable alternatives are frequently not available to meet the elderly's shelter needs. Several options have already been tested and have proved to be successful. These include shared housing, accessory apartments, and ECHO (Elder Housing Cottage Opportunity) housing.

NCBA supports the development of alternative housing arrangements to meet the varied needs of elderly persons. Additionally, the Department of Housing and Urban Development (HUD) should undertake demonstrations to test out other promising approaches.

Promoting Minority Sponsorship

The sponsoring organization undoubtedly has a significant influence upon the racial composition of the residents of federally-assisted housing projects, such as Section 202 housing for the elderly and handicapped. Minority sponsors tend to locate project sites in areas where higher concentrations of aged minorities live. This makes it easier for elderly minorities to make an application to become a tenant.

The Department of HUD should promote increased minority sponsorship of Section 202 housing projects and other programs as well. Technical assistance, for example, can be helpful for minority applicants to meet the necessary requirements to pass muster to qualify for Section 202 loans.

Promoting Equal Access To Housing

Civil rights statutes now prohibit discrimination in housing because of race, sex, religion, or age. However, discrimination still exists.

NCBA reemphasizes that existing laws prohibiting housing discrimination should be fully and vigorously enforced.

Concern About Vouchers

NCBA is concerned about the voucher approach to improving housing conditions for older Americans. This systems provides money directly to persons to help pay for their housing in the open market.

NCBA fears that this approach may simply become a subsidy for inadequate housing without improving the supply of quality housing for the elderly poor. Aged Blacks may be the big losers if a voucher system should replace future commitments to build Section 202 and other housing for the elderly.

The supply of rental housing for older Americans is already limited. Low-income older Blacks are especially hard hit by our nation's failure to develop affordable and pleasant apartment units, since they are much more likely to be renters than elderly Whites.

A voucher system—which simply makes money available for an already inadequate number of quality housing units—will not increase the supply. Instead, it will increase demand, which almost assuredly will drive up the present high housing costs in most urban areas of our nation.

Repeal 30-Percent Cap on Rents

Tenants in federally-assisted housing projects can be charged rent equal to 30 percent of the family's monthly adjusted gross income. In 1986, the cap was fixed at 25 percent. Thus, the increase in the rent ceiling from 25 to 30 percent of adjusted gross income can produce a 20-percent rent hike for low-income tenants residing in public or Section 8 housing.

This can impose a financial hardship for aged persons struggling on limited income because of the unique and additional household expenses that are directly related to old age. Congress should reduce the cap on rents for public housing and Section 8 tenants from 30 percent to 25 percent of an elderly family's monthly adjusted gross income.

CHAPTER V: IMPACT OF CRIME UPON OLDER BLACKS

I. INTRODUCTION

Crime has had a chilling and frightening impact on the lives of Americans, whether they live in cities, suburbs, or rural areas. Nearly one-half (45 percent) of all Americans feel unsafe walking alone at night in their neighborhoods, according to a 1983 Gallup poll. About three out of four (76 percent) women have this fear.

Most people in the U.S. believe that crime is becoming an even more serious problem. Recent Gallup and Harris polls confirm this finding. In fact, 68 percent of Americans believe that crime is on the upswing, compared to 48 percent in 1978,

Crime has not only changed the fabric of our lifestyles. It has also seriously eroded confidence in our criminal justice system. Fear and distrust have become widespread because crime is now so prevalent in our society. Crime has struck at the very heart of our government by undermining respect for fundamental institutions.

A. Crime in the United States

The figures are shocking. Today, the United States has the highest crime rate, by far, among industrialized democracies. It is 20 times higher than the rate in Great Britian and 100 times the rate existing in Japan.

About one out of every four (26 percent) households in America—22.8 million in all—was victimized by crime in one form or another in 1984. Nearly 6 million individuals—3.2 percent of all Americans—were victims of violent crime (rape, robbery and assault). Black males are more than six times as likely to be murdered than White males. They have a 1 in 21 chance of being murdered during their lifetimes, compared to 1 in 131 for White males.

Crime exacts a heavy toll on our society—socially, phychologically, and economically. Victims suffered losses totaling $10.9 billion in 1981 from: (1) personal crimes of violence and theft and (2) household crimes of burglary, larceny and motor vehicle theft. Almost three-fourths of this cost—about $8.1 billion—was attributed to household crimes.

Despite the gravity of the situation, the vast majority of crime is not reported in our society. Only about one of every three crimes is reported to the police. Almost one-half of all violent crimes are reported, but only one-fourth of personal crimes and one-third of household crimes are ever reported.

Most felony arrests do not go to trial. Anywhere from one-third to more than one-half of all felony arrests are rejected at screening by the prosecutor or dismissed. More than half of the rejections at screening are because of evidence-related deficiencies or witness

problems. Approximately 45 out of every 100 felony arrests produce a guilty plea from the offender.

B. Victimization Among Aged Blacks and Other Older Americans

Persons 65 or older are much less likely to be victims of crime than other age groups, particulary teenagers and persons in their early 20's.

1983 VICTIMIZATION RATE PER 1,000 PERSONS OR HOUSEHOLDS

Age	Personal violence	Crimes theft	Household crimes
12–15	51	125	395
16–19	65	119	NA
20–24	60	119	256
25–34	42	88	NA
35–49	20	73	217
50–64	9	44	146
65+	6	23	95

NA—Not Available

Source: "Crime and Justice Facts, 1985," U.S. Department of Justice, Statistics, May 1986, p. 4.

These figures, though, are extremely misleading if viewed in isolation. There are three primary reasons that crime is a more serious problem for the elderly than the raw figures suggest.

First, a substantial amount of crime is never reported because older Americans fear retaliation. Consequently, the reported victimization rates are deceptively low. Many victims are also silent because they have grave doubts that their assailants will ever be prosecuted, convicted, and imprisoned.

Similarly, witnesses are also reluctant to cooperate with the criminal justice system because of the fear of reprisals or lack of confidence in our law enforcement system.

Elaine Hirsch, Director of the Advocacy Division for the Illinois Attorney General, may have summed it up best when she said:

> . . . At the federal level they seem to be telling us that crimes against the elderly is not a severe problem and that everything possible has already been done to combat it. As usual, we find the federal government makes its case with statistics. They have very little relation to this problem.
>
> The truth is that the problem of crimes against the elderly is complicated by the factors that the administration ignores. These factors make available statistics meaningless. The truth is that crimes against the elderly are underreported and underinvestigated, and that as a result elderly crime victims are clearly underserviced.
>
> The system and the statistics have failed to take the human factor into account. For very human reasons, such as insecurity, frailty and fear, the elderly are more vulnerable to crime, more devastated by it, and much less likely to report it.
>
> The truth that we must face is that the elderly victim of crime is victimized at first by the offender and then by the

system. And the really disturbing truth is there is at present a very serious failure of justice.[48]

Second, the aged tend to be victimized less because large numbers live under a form of house arrest. This solution may provide more security for the elderly, but it also cause them to be imprisoned in their homes, cut off from their family, friends and vital services. It has changed the whole fabric of their lives.

Third, no statistics can accurately depict the personal trauma and fear of being victimized. The impact for the aged is likely to be more lasting and traumatizing. A bruised and beaten elderly victim usually takes much longer to heal than a younger victim. A theft of $50 from an aged Black will probably cause hardship because he or she is much more likely to live in poverty than a younger victim.

Older Blacks are far more likely to be victimized by crime than aged Whites. The following summary provides a comparison of the victimization rates.

Murder.—Elderly non-Whites (largely older Blacks) are more than 5 times as likely to be murder victims than Whites 65 or older. In 1984, the murder victimization rate was 15.83 per 100,000 aged non-Whites compared to 3.06 per 100,000 Whites 65 or older. (Source: Federal Bureau of Investigation, U.S. Department of Justice.)

Robbery.—Aged non-White males (primarily Blacks) are 2.7 times more likely to be robbery victims than older White males. The robbery victimization rate was 779 for every 100,000 elderly non-White males, in comparison to 290 per 100,000 White males 65 or older in 1984. The robbery victimization rate was 4.6 times as great for non-White females 65 or older than aged White females: 730 per 100,000 older nonwhite (predominantly Black) females versus 160 per 100,000 for White females.

Assaults.—Elderly non-White males (predominantly older Blacks) had an assault victimization rate 1.5 times that for White males 65 or older: 603 per 100,000 population in 1984 vs. 402 per 100,000 population. However, the assault victimization rate was more than twice as great for White females than non-White (primarily Black) females: 220 per 100,000 aged White females compared to 90 per 100,000 non-White females 65 or older.

Personal larceny with bodily contact.—The victimization rate for personal larceny with bodily contact for aged Black males and other non-White males was 3.8 times greater than for elderly White males: 448 per 100,000 population compared to 119 per 100,000 population. The rate was nearly twice as great for non-White females (660 per 100,000 population) than for White females (360 per 100,000).

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[48] Testimony presented at Chicago forum on "Crime Against Black Elderly", Aug. 18, 1986, pp. 13–14.

CRIMINAL VICTIMIZATION RATE (PER 100,000 POPULATION) FOR OLDER AMERICANS IN 1984

	Males Black and other races	White	Females Black and other races	White
Robbery	779	290	730	160
Assaults	603	402	90	220
Personal: Larceny with Contact	448	119	660	360

Source: "Sourcebook on Criminal Justice Statistics—1984," Bureau of Criminal Statistics, U.S. Department of Justice, pp. 298–299.

II. THE CHICAGO FORUM

Widespread fear, apathy, and powerlessness exist among aged Blacks and other older Americans who now live in high-crime areas. In far too many cases, they attempt to retreat to the sanctuaries of their own homes. But, they frequently find that their own homes are not secure from burglars, vandals, or other criminal assailants. Criminals find older Americans to be tempting prey because they are generally slower-moving and less able to resist attack than younger persons.

A. What Happens When Crime Gains the Upper Hand?

Elderly Blacks in federally-assisted housing projects have told NCBA staff in moving terms what happens when crime gains the upper hand. They have described very graphically what it means to be mugged, beaten, and abused. Their whole living environment and life style are affected. Doctors may decline to enter the project when they are sick. Drug stores, grocery stores, and department stores refuse to make deliveries. Taxicabs do not respond to calls from project tenants.

Small neighborhood stores board up and go out of business. The walk to buy food and other everyday necessities becomes longer and more dangerous. Friends and neighbors may call on the phone, but they do not visit. Vandals constantly break elevators, forcing long climbs up dark stairways that are ideal hiding places for assailants.

B. Accounts of Elderly Black Victims

These points were all made powerfully and eloquently at the Chicago forum. Laurette Dawkins, an elderly victim, described the steps that she takes to minimize the likelihood of being victimized:

> . . . I have four locks on my front door, four locks on my back door, one alarm on the front door, one alarm on the back door, gates to the front, gates to the back, gates to the windows. Now when I go in my apartment I have all of this to unlock. Then when I shut the door it sounds like I've shut myself in prison. You hear the clanging of the gates and the locks. Well, I feel I'm halfway safe, but they tell me locks are not made for criminals. I can't go to church. I can't come out of the building at night by myself. I can't come back from church at night by myself. I have no one else to travel with. You're afraid to get on the buses at night because you have the derelicts on the

bus, the dope addicts on the bus, and you don't know what they're up to. You're just frightened.[49]

Ms. Dawkins added:

> . . . What crime prevention techniques do you use to protect yourself and your family? I use locks. I have bars. We use a safety deposit box at the bank and pray.[50]

Georgia Day attended the Chicago hearing with a lame arm because she had been struck the previous Thursday when an assailant attempted to snatch her pocketbook. The aftermath from this episode was minor, however, when compared to the grief suffered by Mrs. Day after her husband and son had been homicide victims earlier. She gave this moving account:

> . . . the boy that killed my son was already indicted on suspicion of murder. So, he got a murder, and only thirty-five years for my boy's life. You see, these things make you wonder. It takes the stability away from a senior citizen when you are trying to do things. It throws you off guard. I'm just now beginning to come back to myself. With the love of the people, some of the people in the neighborhood, and Mr. Ahrens and his staff, I'm finding my way back, but it's a hard, hard journey. Everybody wants to say you're senile, or you're this or you're that, but nobody knows, with two violent deaths in your life, how you can walk. And I'm seventy-six.[51]

Rebecca McGlothin, the American Association of Retired Persons' Criminal Justice Services Liaison for the City of Chicago, rebutted the notion that crime is not as serious a problem for older Americans as it is for younger Americans. She said:

> . . . In addition to violent crimes, older persons are the favorite and, hence, principal victims of crimes such as criminal fraud, strong-arm robbery, purse snatching, theft of checks from mail boxes, vandalism and harassing telephone calls. For this reason, Mr. Congressman, and because crime has a unique exaggerated effect on the lifestyle and emotional well-being of older victims, crime has consistently been cited by the older Americans of all races and income levels as being one of their major concerns.[52]

III. RECOMMENDATIONS

Aged Blacks and other older Americans are frequently more seriously victimized by crime because of their limited income and physical condition. Fear of victimization can greatly change the lifestyle of the elderly, especially those living in crime infested areas. Yet, several positive actions can be taken—and quite often at low or

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[49] Testimony presented at Chicago forum on "Crime Against Black Elderly", Aug. 18,1986, pp. 132-133.

[50] Testimony presented at Chicago forum on "Crime Against Black Elderly", Aug. 18, 1986, p. 94.

[51] Testimony presented at Chicago forum on "Crime Against Black elderly", Aug. 18, 1986, pp. 68-69.

[52] Testimony presented at Chicago forum on "Crime Against Black Elderly", Aug. 18, 1986, pp. 1-2 of written statement.

minimal cost—to prevent crime and alleviate the fears of older Americans. NCBA recommends the following actions be taken:

Strong Handgun Control Laws

A strong handgun control law should be enacted as soon as possible to keep dangerous weapons out of the hands of criminals and other potentially dangerous persons. Most western democracies have stringent laws to limit the possession of handguns. These measures have proved to be effective deterrents to murder by firearms because their criminal homicide victimization rates are normally substantially below those of the United States.

Emphasis on Crime Prevention Techniques

Our nation's efforts to combat crime should focus on preventive techniques. Several methods have already been tested, and the results have generally been positive. The key is to educate the public about effective crime prevention techniques, such as security checks, escort services, neighborhood watches, and the installation of security devices.

Community Involvement Is Indispensable for Crime Prevention

The involvement of people in the local community is an indispensable element in combating crime. Police departments can assist by training people concerning effective steps to reduce the likelihood of being victimized. Police can also help organize community groups to conduct community watches and encourage people to report crimes. Without community encouragement, many older Blacks and others may not know how to effectively resist crime in their neighborhoods.

Aged Involvement in Plea Barganing

Elderly victims should bve involved when the criminal justice system engages in plea bargaining negotiations with alleged criminals. Every effort should be made to assure the victim that plea bargaining arrangements will be negotiated only in cases when the criminal assailant is not expected to commit another crime. Today, many elderly Blacks and other Americans view the plea bargaining process with suspicion and deep concern. In large part, this is because a criminal assailant may soon be out on the street after more serious charges are dropped for a guilty plea to a lesser offense.

Stiffer Sentences for Criminal Offenders

Federal and State criminal courts should impose stiffer sentences for assailants who victimize older Americans. This can be a tool to help deter crimes against elderly persons. Moreover, more aged Blacks and other older Americans will quite likely be more willing to cooperate with the criminal justice system if they believe that their offenders will be imprisoned and not out on the streets again to retaliate against them after a slight slap on the wrist by authorities.

Reduce Recidivism

Our prison system needs a major overhaul to prevent recidivism among inmates who are later released. Two major objectives of imprisonment are to (1) deter crime and (2) rehabilitate the offender. Unfortunately, our prison system fails to achieve both objectives. Many inmates are soon practing their criminal acts after they have completed their prison terms. Kathryn Anderson, past President of the Chicago Metro Seniors in Action, summed it up well when she said:

> Stop recidivism by having more humane conditions in our jails and prisons. Have a trade taught that can be used on the outside, and also teach prisoners how to read. Statistics show that sixty percent of the prisoners are functionally illiterate. And have more halfway houses when they are released. Many of them return because they go back to the same environment, cannot find a job because of their background, and having no alternative, return to dope in their frustration and to crime to support their habit.[53]

Control Violence on Television

Violence on television should be limited. Most Americans spend a good portion of their day watching televison. Much of their viewing time is saturated with acts of murder and other forms of violence. This is also true for movies. Respected researchers have concluded that there is a connection between the high degree of violence in the United States and the constant repetition of violent acts in the movies and television. Senior citizens and organizations that represent them should establish a dialogue with film producers and television executives to reduce the emphasis on violence in both movies and television.

[53] Testimony presented to Chicago forum on "Crime Against Black Elderly", Aug. 18, 1986, p. 129.

CHAPTER VI: SERVICE NEEDS OF OLDER BLACKS

I. INTRODUCTION

Income alone cannot solve all the problems confronting elderly Blacks and other low-income older Americans. An effective services strategy is also necessary to complement a comprehensive and soundly conceived national retirement income policy because many of the aged's basic problems transcend economic considerations.

One notable example is transportation. It may pose a dilemma for the more affluent elderly as well as the aged poor, especially those who neither drive automobiles nor own cars. Elderly persons who have transportation at their disposal find it much easier to cope with challenges related to advancing age. But "without wheels", the daily living experience can become a form of imprisonment. Routine tasks for most Americans—such as shopping, visiting friends, or going to the doctor—can become major problems for aged individuals without a car or suitable public transportation. Unfortunately today, far too many older Americans live under a form of "house arrest" because public transportation is often unavailable, inaccessible, or too expensive.

Congress enacted the Older Americans Act in 1965 to deliver a wide range of services for the aged. During the past two decades, the Older Americans Act has evolved to the point where it is now a primary source for delivering a wide range of services to elderly persons, either directly or by leveraging funds from other programs. These services include home health care, homemaker services, transportation, outreach, information and referral, congregate meals, and home delivered meals.

Other programs—such as the Social Services Block Grant, Community Services Block Grant, and Congregate Housing Services—also provide services for Older Americans. However, the Older Americans Act has emerged as the focal point for responding to the services needs of individuals 60 or older. Consequently, this chapter will focus more attention on the Older Americans Act in responding to the service needs of elderly Blacks. This becomes all the more important because Congress must decide whether the Older Americans Act should be renewed in 1987.

A. Underserved in Older Americans Act Programs

Researchers have generally agreed that older minorities have a greater need for services than aged Whites. In large part, this is because elderly Blacks and other minorities are normally about two to three times as likely to live in poverty as aged Whites. Earlier equity studies conducted for the Administration on Aging (AoA) during the late 1970's concluded that the need for services

among aged minorities is 2 to 3½ times as great as for the non-minority elderly.

Despite the serious problems encountered by aged Blacks and other elderly minorities, they continue to be underserved in Older Americans Act services programs when measured against their need for services. This point has been made emphatically in AoA funded equity studies and the 1982 Civil Rights Commission report.

Moreover, the situation seems to be deteriorating rather than improving. In fact, the minority participation rate for the Older Americans Act Title III-B Supportive Services program has dropped nearly one-fourth (24.7 percent) during this decade, from 21.9 percent in FY 1980 to 16.5 percent in FY 1985. Since FY 1980, the minority participation rate has declined every year except for 1982, when it remained unchanged. The 1985 participation rate represents an all-time low for the 1980's.

A similar pattern exists for the Title III-C Nutrition Program for the Elderly. The minority participation rate has fallen every year since FY 1980, except for 1983. Overall, the minority participation rate has dipped by 13.7 percent, from a high of 19.0 percent in FY 1980 to a low of 16.4 percent in FY 1985.

MINORITY PARTICIPATION IN TITLE III SUPPORTIVE AND NUTRITION SERVICES

Fiscal year	Total	Minorities	Percent minorities
Supportive services:			
1980	9,336,993	2,047,007	21.9
1981	8,885,747	1,607,229	18.1
1982	9,160,079	1,653,980	18.1
1983	9,171,609	1,625,390	17.7
1984	9,126,122	1,597,589	17.5
1985	9,331,154	1,535,112	16.5
Nutrition services:			
1980	3,083,454	585,584	19.0
1981	3,400,952	644,203	18.9
1982	3,355,778	603,996	18.0
1983	3,759,222	705,258	18.8
1984	3,530,288	610,052	17.3
1985	3,630,177	595,619	16.4

Note: 1980 figures refer to participation for approved area plans.

Source: Administration on Aging, U.S. Department of Health and Human Services.

Nearly 300,000 fewer aged Black received Title III-B Supportive Services in FY 1985 than in FY 1980—1,000,000 (rounded to the nearest thousand) in 1985 compared to 1,298,000 (rounded to the nearest thousand) in 1981. The elderly Black participation rate fell by 23.0 percent during this period, from a high of 13.9 percent in FY 1980 to a low of 10.7 percent in FY 1985. During the past decade, the aged Black participation rate fell every year with the exception of 1983 when it rose slightly.

The older Black participation rate for the Nutrition Program for the Elderly dipped by 9.8 percent during this decade, from 11.2 percent in FY 1980 to 10.1 percent in FY 1985. This, too, represents the lowest participation rate during the 1980's.

AGED BLACK PARTICIPATION IN TITLE III SUPPORTIVE AND NUTRITION SERVICES

Fiscal year	Supportive services		Nutrition services	
	Aged blacks	Percent aged blacks	Aged blacks	Percent aged blacks
1980	1,297,767	13.9	346,487	11.2
1981	1,052,762	11.8	378,782	11.1
1982	1,049,617	11.5	345,593	10.3
1983	1,074,810	11.7	376,518	10.0
1984	1,034,958	11.3	380,297	10.7
1985	1,000,302	10.7	366,697	10.1

Note: 1980 figures refer to paticipation for approved area.
Source: Administration on Aging, U.S. Department of Health and Human Services.

B. Why Are Aged Blacks and Older Minorities Underserved?

Why have aged Blacks and older minorities been underserved under the Older Americans Act, especially when measured against their need for services? There is no simple answer to this preplexing question.

Betty Kozasa, Associate Executive Director for the Volunteer Center of Los Angeles and Chairperson for the Advisory Council for the National Pacific/Asian Resource Center on Aging, summarized earlier research on this subject at the Los Angeles forum.

She said:

> One of the most fundamental issues for the reauthorization of the Older Americans Act is to assure that aged minorities are more equitably served. The 1982 Civil Rights Commission report plus earlier equity studies of the Administration on Aging (AoA) have made three key points:
>
> 1. Older minorities have a greater need for services than Whites, typically 2 to 3½ times as great as for the non-minority elderly.
> 2. Aged minorities have not been served under the Older Americans Act according to their needs.
> 3. Elderly minorities have been inequitably served under the Older Americans Act.[54]

Research, government studies, Congressional hearings, and NCBA forums have documented several reasons why aged Blacks and other low-income elderly minorities have not been served adequately by Older Americans Act and services programs.

These include:

—Aged minorities frequently feel that Older Americans Act programs were not responsive to their needs and priorities.

—Elderly Blacks and other older minorities are often under-represented or not represented at all on advisory councils for the service delivery planning process.

—Senior centers may be located in areas which are inconvenient or inaccessible for aged minorities.

[54] Prepared Statement of Betty Kozasa at Los Angeles forum on "Service Needs of Older Blacks", Sept. 19, 1986, p. 1.

—Transportation can be a serious problem for obtaining necessary services, especially for low-income seniors without an automobile.
—The fear of crime may deter elderly Blacks and other low-income minorities from venturing out in public to receive necessary services.
—Nutrition sites may not provide culturally appropriate meals.
—Publicity about services programs tends to be limited, especially in languages other than English.
—Area Agencies on Aging do not generally conduct vigorous outreach efforts to locate more older minorities, according to the Civil Rights Commission report.
—The aging network has not been diligent in monitoring participation by elderly minorities, according to the 1982 Civil Rights Commission report.
—Efforts to promote "volunteer" contributions at nutrition sites, especially if they are pursued in an overly aggressive fashion, can inhibit aged Blacks and other low-income minorities from participating fully. Steps are supposed to be taken to insure that no one is humiliated. However, proud low-income seniors may be deeply embarrassed if they are unable to contribute when they know that others at the nutrition site are paying partially or fully for their meals.

The list of reasons could go on and on. The point, though, is that several factors account for the low and declining participation rates for aged Blacks and other elderly minorities in recent years.

II. THE LOS ANGELES FORUM

Congressman George W. Crockett, Jr. (D–MI) chaired the Los Angeles forum. He quickly put the forum's focus in proper perspective in his opening statement:

> . . . Despite the fact that there are more older Americans now than there were in 1980, there are fewer Black seniors who are receiving meals, and nearly one-quarter fewer older Blacks are now getting supportive services such as adult day care and home health care. We need to figure out why, and we need to ask ourselves how we go about correcting this problem.[55]

A. Professionals in the Field of Aging

Administrative personnel and professionals in the field of aging generally reaffirmed the findings from earlier studies concerning the need to bolster minority participation in Older Americans Act programs. They also focused on special reasons which were applicable to California. One such example is the application of the intrastate funding formula in California, which Paula Smith, Assistant General Manager for the Los Angeles Area Agency on Aging, alluded to in her prepared statement:

> The State of California, as it allocates the Older Americans Act funds to the City of Los Angeles and the rest of the state,

[55] Opening statement at Los Angeles forum on "Service Needs of Older Blacks", Sept. 19, 1986, p. 6.

utilizes an intrastate funding formula based upon population and weighted also by characteristics of "greatest economic and social need" but restricted in impact because of provisions in the state law (Section 9315 of the Welfare and Institutions Code) which does not allow allocation of funding according to the formula itself. These provisions add factors to the formula that tend to favor non-urban areas, thereby reducing funds to urban areas, such as the City of Los Angeles. By diluting the federal "targeting" requirement, the State of California severely hampers local efforts to enhance and increase service delivery to minority seniors, including the Black aged.[56]

In subsequent questioning, she later explained that a "hold harmless" (prevent a reduction in funding) clause for certain communities caused funds to be reduced for urban areas. This, in turn, limited available money to provide more services for aged Blacks and other minorities.

Josephine Whitfield, Program Director for the Watts Labor Community Action Committee, emphasized that suggested donations can drive away aged Blacks and other low-income elderly persons from services sites. She gave this example:

The suggested donation currently is $0.75 or more for nutrition; $0.50 for one-way transportation; and $0.25 for other supportive services. It is a known fact that Blacks are the poorest of the minority older persons, yet we are forced to expect the same suggested donation from them as from others. This, therefore, restricts some Black older persons from participatng in these services . . . So this means, if they don't have the money for the suggested donation, they elect not to participate in the programs.[57]

Ms. Whitfield also noted that rising insurance and other operating costs have inhibited the ability of program administrators to deliver needed services to older persons.

B. National Aging Organizations and Older Consumers

Older consumers and representatives from national aging organizations contributed to the solid testimony presented at the Los Angeles forum. Mary Shields, a volunteer Tax-Aide Coordinator for the American Association of Retired Persons, pointed out that the minority contractors were frequently underrepresented in Older Americans Act programs. She gave this assessment:

Two other interesting points emerged from the Commission report. The first was that minority firms were usually underrepresented in receiving Title III (supportive services/nutrition) awards despite their unique services and positive track records on capacity to deliver quality services. Second, minorities were underrepresented in employment within the aging network and frequently were hired in lower status and low-paying jobs. Area Agencies on Aging typically did not have a formal re-

[56] Prepared statement by Paula Smith at Los Angeles forum on "Service Needs of Older Blacks", Sept. 19, 1986, p. 3.

[57] Prepared statement by Josephine Whitfield at Los Angeles forum on "Service Needs of Older Blacks", Sept. 19, 1986, p. 1.

cruitment process to increase employment opportunities for minority individuals.[58]

III. RECOMMENDATIONS

The Older Americans Act continues to be the primary source for funding supportive services for persons 60 or older. In FY 1985, 9.3 million older Americans received a wide range of Title III-B supportive services. These services—such as homemaker or home health—have enabled aged persons to continue to live independently in their communities rather than being placed prematurely in a nursing home at a much higher public cost.

Nearly 215 million nutritious meals were served to elderly persons in 1985 under the Older Americans Act, including 154 million in group settings and 61 million home-delivered meals. Quite often, this program provides the only nutritious meal that the elderly will receive on a particular day. The congregate meals programs has been especially helpful for lonely shut-ins by enabling them to meet and talk with others.

However, a clear need exists to serve aged Blacks and other minorities more effectively. NCBA considers equitable treatment for elderly Blacks and other aged minorities to be the single most important issue for the reauthorization of the older Americans Act.

Enforcement of Existing Provisions for Older Minorities

Congress enacted a number of provisions in the 1984 Amendments to improve minority participation in Older Americans Act services programs. One example is a measure to clarify that low-income minorities are a priority group for receiving services. In addition, AoA is required to consult with national minority organizations in developing training packages and providing technical assistance to help state and Area Agencies on Aging deliver services to the elderly with the greatest needs.

These provisions are constructive steps to improve minority participation in Older Americans Act programs. AoA must effectively monitor these measures to insure that they are properly implemented.

Served on Basis of Need for Services

The 1984 Older Americans Act Amendments emphasized that low income aged minorities are a priority group for receiving services. NCBA believes that it is necessary now to go one step further—by stating affirmatively that elderly minorities should be served on the basis of their social or physical need for services.

Advisory Councils

NCBA also favors new statutory language to promote the appointment of minorities on advisory committees and other units of Area Agencies on Aging and state offices on aging. These panels can be influential in determining what types of services will be of-

[58] Prepared statement by Mary Shields at Los Angeles forum on "Service Needs of Older Blacks", Sept. 19, 1986, p. 2.

fered and where they will be located. These decisions are often critical in deciding who is served under the Older Americans Act and how well they are served.

Promote Employment, Grant, and Contract Opportunities

Affirmative steps are also needed to promote employment, training, and contract opportunities for minorities in the field of aging. The 1982 Civil Rights Commission report found that minorities have not participated fully under the Older Americans Act. When minorities have participated, the typically have been in a lower-level capacity.

Statutory language is necessary to state clearly that federal, state and local offices on aging should establish appropriate targets, goals, and timetables for increasing on-the-job training, employment, grant, and contract opportunities for minority individuals and business enterprises.

AoA should develop suitable regulations, guidelines, and program instructions to implement these recommendations. In addition, relevant data should be collected concerning: (1) employment and training positions for minorities at state and local offices on aging and AoA; (2) service contracts and grants for minority enterprises under the Older Americans Act, and (3) minority participation in services programs. These efforts can heighten awareness about the problems and challenges facing older minorities. In addition, they can lead to greater participation by today's and tomorrow's minority aged in all Older Americans Act activities.

Opposition to Proposals Diluting Minority Participation

Earlier recommendations have been advanced for the purpose of promoting minority participation in all Older Americans Act programs. However, it is also important to be wary of measures which can dilute minority participation in the Older Americans Act services programs.

Recent legislation proposals include those designed to redirect more Older Americans Act resources to the so-called "vulnerable elderly". One measure would amend the definition of "greatest social need" to include vulnerable older persons. Another proposal would allocate Title III funds according to the 65-plus population rather than the 60-plus population as authorized by present law. In addition, a draft document has called for the promotion of community-based services.

NCBA is not opposed to serving vulnerable older persons. However, the recommendations for the "vulnerable elderly" typically involve health-related services, which, in the judgment of NCBA, are more appropriately provided through other legislation rather than through the Older Americans Act. As a practical matter, these services for the vulnerable aged will probably cost more and dilute existing limited resources for current client groups under the Older Americans Act. This does not make sense, especially since the minority participation rate under Title III Supportive and Nutrition Services has already fallen sharply. In fact, the aged minority participation rate is at an all-time low during this decade for both the supportive services and the elderly nutrition programs, even

though low-income aged minorities have the greatest need for these services.

Improved Information and Outreach Services

Our nation has established a number of so-called "safety net programs" to protect low-income older and younger Americans if they should fall or slip economically. However, only a relatively small percentage of the aged poor are actually protected by the programs. For example, only 29 percent of elderly households living in poverty actually receive food stamps. Only about one of every three (36 percent) non-institutionalized aged poor are protected by Medicaid.

Several reasons account for the low participation of older Blacks and other low-income persons in these "safety net programs". One important factor is that many are unaware of these programs or have inadequate information about eligibility requirements. A concerted effort is needed to overcome this lack of awareness to assure that people who are eligible for safety net benefits do, in fact, receive them. Improved information and outreach services should be developed to assure that more aged Blacks and other low-income elderly persons participate in the food stamp, Medicaid, and other "safety net programs".

Bolstering Legal Services

Many older Americans are forced to fend for themselves when legal problems arise—whether these involve litigation, understanding the technicalities of federal programs, or planning their personal affairs. All too often, older Blacks and other low-income elderly persons accept injustice when dealing with government agencies because they do not know what their rights are or they do not have the benefit of informed counsel. Legal services, however, can help to assure that low-income older Americans receive equitable treatment before administrative agencies, the courts, and elsewhere.

NCBA favors the following actions to strengthen legal services for aged Blacks and other low-income elderly persons:

—Legal services should continue to be a priority service for funding under the Older Americans Act.

—Area Agencies on Aging should be required to spend at least 6 percent of Title III-B funds for legal services and for each of the other two priority services: (1) in-home health care and (2) access.

—Elderly persons should have a private right of action to sue for procedural violations under the Older Americans Act.

—Congress should continue to fund the Legal Services Corporation

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